THE FATALITY INQUIRIES ACT

RESPECTING THE DEATH OF LESTER NORMAN DESJARLAIS

ASSOCIATE CHIEF JUDGE BRIAN DALE GIESBRECHT

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## INTRODUCTION

This is my "Fatality Inquiries Act" report concerning the death of Lester Norman Desjarlais.

Lester took his life on March 6, 1988. His death appeared to be an unremarkable suicide, and a decision was made not to call an inquest. Pages 1 - 6 of this introduction will chronicle the history of this inquest. Pages 6 - 18 will deal with preliminary matters that arose during the course of the proceedings. The remainder of the report will be devoted to a discussion of the substantive issues.

The Chief Medical Examiner's office is required to do an investigation into the death of a child who is in the care of a child care agency at the time of the child's death. Lester was a ward of the Dakota Ojibway Child and Family Services Agency when he died. Dakota Ojibway Family Services (DOCFS) is a child care agency that falls under the umbrella organization Dakota Ojibway Tribal Council (DOTC). Hedie Epp of the Chief Medical Examiner's Office was given the task of preparing the report. When she called to make arrangements to review Lester's DOCFS file with DOCFS she ran into difficulties. She was informed that the file had gone missing. It was at that point that the decision not to call an inquest was overturned. That is, because of the missing files, it was decided to call an inquest.

Hedie Epp completed her investigation without the benefit of the files and filed her report. (Exhibit 13)

The Office of the Chief Medical Examiner, in a letter to Chief Judge K. Stefanson dated May 31, 1990 requested that the following concerns of the Inquest Review Committee be dealt with at the inquest, namely:

1. "Clear the air regarding the circumstances that led to this untimely death;

2. An explanation as to the missing file on Lester Desjarlais; and

3. Current policies and security measures pertaining to the case files at the Dakota Ojibway Child and Family Services Agency".

Ombudsman Manitoba also became involved in the case. In a letter to Chief Judge K. Stefanson dated July 10, 1990, Donna Drever, Investigator Child and Adolescent Services with Ombudsman Manitoba, outlined the allegations that Lester had been sexually abused, and requested that the inquest also answer the following questions:

1. "What action was taken by the Dakota Ojibway Child and Family Services to investigate these allegations of sexual abuse and whether any investigations were conducted in accordance with the Manitoba Guidelines Indentifying and Reporting Child Abuse which were in effect at that time?

2. Was the recommendation that Lester receive therapy for sexual abuse acted upon?"

Because of the additional questions submitted by the Office of the Chief Medical Examiner and by Ombudsman

Manitoba, the inquest was broadened considerably beyond a more usual inquiry into the immediate circumstances surrounding death.

The inquest was originally scheduled for August 1, 1990. One day was set aside for the hearing. At some point it became evident to Lawrence McInnes, the Crown Attorney assigned the inquest file, that the inquest would raise many issues that required preparation on his part and that one day was not sufficient for the hearing. The inquest was eventually rescheduled for the week of October 7, 1991.

When the inquest commenced before me on October 7, 1991, Lawrence McInnes appeared for the Crown, and no one appeared for DOCFS, or any other party, although proper notice had been served. The following witnesses testified in October 1991:

Caroline Ann Fisher
Paul Albert Roy
Angus Joseph Starr
Cecil Desjarlais
Morris Clark Merrick
Margaret Anne Raine
William George Richard
Olga Hart
Hedie Louise Epp
Donald Ervin Bechtel
Lillian Starr
Maxine Linda Starr
Cst.Nicholas Luke Greenhill
Joseph Adelard Desjarlais
Nicholas Franklin Petrinack
Elaine Scott
Ernest Ronald Mousseau
John Peter Francis Chudzik
Doreen Elizabeth Loane
Esther Seidl
Marion Florence Glover

But it was one witness, Marion Glover, who was the most controversial. Ms. Glover, a former employee of DOCFS, made numerous allegations of incompetence and negligence on the part of DOCFS that may have contributed to Lester's death. For their part, DOCFS employees testified that it was Marion

Glover who was incompetent and negligent, and that DOCFS acted properly.

With regard to the missing files the DOCFS position was uncomplicated. Marion Glover had stolen the files, probably to cover up her incompetence and negligence. Marion Glover denied stealing the files and accused either someone within DOCFS, most probably Morris Merrick or Ernie Daniels, or someone at Sandy Bay, most probably Cecil Desjarlais, of stealing the files.

The scope of the inquest was becoming broader and broader with these allegations. The case of another child, Donna Desjarlais (a relative of Lester) was used by DOCFS as an example of Marion Glover's incompetence, and by Marion Glover as an example of the incompetence of DOCFS. Witnesses began to come forward to offer information that they felt was relevant.

It was under these circumstances that the inquest recessed in October 1991. Lawrence McInnes announced that he intended to call a number of additional witnesses to shed light on the new matters. He also wanted to obtain transcripts of the proceedings to date, and because they were not available for some time, it was not possible to reconvene the inquest until the new year. The matter had to be rescheduled to April 6, 1992 as a result of a health concern within the family of counsel.

In the meantime, Marion Glover made attempts to retain counsel to represent her at the inquest continuation. She

was unable to do so. DOCFS retained Douglas Paterson to represent their agency.

Lawrence McInnes prepared a list of witnesses that he determined to be necessary to complete the picture. In addition to his list, Lawrence McInnes added witnesses requested by both Doug Paterson and Marion Glover. I did not participate in this process, or screen the list prepared by Mr. McInnes and the other parties. It is my opinion that the Crown is responsible for the inquest witness list, and the order of calling witnesses, in the same way as the Crown is responsible in a criminal trial. The Court has a residual discretion to call witnesses, but I exercised that discretion in a limited way. I am also of the opinion that the Crown's decision to add witnesses requested by both Marion Glover and Doug Paterson was fair and reasonable in this case. The result was a long list of witnesses, and a lengthy hearing.

When the inquest reconvened, Marion Glover made application to be granted intervener status for the remainder of the inquest, and asked that she be allowed to represent herself. I granted her application. To deal with the question of the missing files alone, where DOCFS accused Marion Glover of stealing the files, and Marion Glover accused DOCFS or someone at Sandy Bay, it was my opinion when I granted the application, and it is my opinion now, that Ms. Glover required more than witness status, and had

to be allowed to question witnesses and make submissions in the same way as counsel for DOCFS, who was given that right.

It would have been preferable if Marion Glover had retained counsel. Marion Glover is not a lawyer. However, Ms. Glover did not have funds to pay a lawyer, and I was satisfied that she had made every reasonable effort to obtain assistance to retain counsel. No authority exists under the Fatality Inquiry Act similar to Section 11 of The Young Offenders Act allowing a court to appoint counsel, and the Provincial Court is statutorily fed, enjoying no inherent jurisdiction. I reluctantly concluded that Marion Glover would have to represent herself.

Having made that decision, it was clear to me that if I dealt with evidentiary objections in the usual manner, Marion Glover would be at a severe disadvantage. Either Marion Glover would be prevented from asking questions she felt relevant, by her lack of legal expertise, or the inquest would become so bogged down by objections and their resolution, that the witnesses would not be able to tell their stories. So, I allowed Marion Glover wider latitude on questioning than would normally be the case. As it turned out, Marion Glover proved to be very good at questioning witnesses, and her ability to understand basic rules of evidence was obvious. I may have been too cautious at the outset of the hearing, and as the hearing went on, I relaxed restrictions on objections by Doug Paterson to Marion Glover's questions.

Related to this was a cultural issue, which I think should be borne in mind when questioning traditional aboriginal witnesses. As explained by Joyce Wasicuna, a former DOCFS employee, who described herself as a traditional native person, traditionally an aboriginal person would expect to be able to say what he or she has to say without interruption. Even if the person speaking appears to be off topic at a particular time, that might be considered necessary by the person to arrive at his or her point. It is considered very rude to interrupt the speaker, especially with sharp, pointed questions. Now in fact the trial method, with direct examination followed by cross-examination and lawyers admonishing a witness to stay on topic and interrupting, and at times speaking in angry tones, is culturally offensive and unnatural to aboriginal tradition. There is not much that can be done about this, short of completely changing a system that has evolved over centuries. But, I believe we can make some allowances when questioning an aboriginal person who is elderly and/or from the traditional aboriginal community, as opposed to an urban person. It may be appropriate to allow that witness more latitude in telling his or her story, even if it means restricting objections from counsel, or even asking counsel on cross-examination to refrain from asking questions with a raised tone of voice, or adopting a highly confrontational style. In this case some of the witnesses, and I use Virginia and Arthur Roulette as examples, fell into this

category. They were very obviously uncomfortable and embarrassed in the court setting, and it behooves the court to try to allow them to be as comfortable as possible so that they can tell their stories, even if it means making counsel a bit uncomfortable.

Isaac Beaulieu, Chairman of DOCFS, suggested that in the case of witnesses like Virginia and Arthur Roulette the court might consider meeting with the Roulettes at their home, and rather than asking questions in the cold, surgical method expected in the present system, let the people tell their stories in their own way. This might be a useful approach in the cases of key witnesses.

Mr. Beaulieu also suggested that future hearings involving aboriginal people might look at the method employed within the Navajo system. Witnesses make statements. There is no cross-examination, but instead, after the statements have been made, consensus building begins, and the result is obtained in this way. In fact, this is exactly the way the local child welfare committees, which will be discussed in detail in this report, were designed to function. In Mr. Beaulieu's words "going in there are disagreements, and coming out there is agreement".

Another example is the case of Dennis Roulette, a witness who came forward to say that he was asked by Cecil Desjarlais to destroy child welfare files. Typical hard-edged questioning by Lawrence McInnes and Doug Paterson (and I make no criticism here of their styles - they were using

the usual clipped, clear questioning we expect in our system), yielded very poor results. It was only when Marion Glover questioned him that she was able to draw out what Mr. Roulette had really come to say. She asked her questions in the manner of one friend talking to another, and it was clearly appreciated by Dennis Roulette.

The final example I will use on this point is the example of Cecil Desjarlais. Mr. Desjarlais is a resident of the Sandy Bay Reserve who is accused at this inquest of "political interference" in the affairs of DOCFS. He will be referred to frequently in this report. When Mr. Desjarlais testified on May 13, 1992 it was clear to me that he wished to make a statement before submitting to questions. I allowed him to do so, and Mr. Desjarlais proceeded to make a long rambling speech. In doing so, Mr. Desjarlais was making it clear to the inquest that his time was valuable, and that he was a person to be respected. I did not interfere with Mr. Desjarlais's "opening statement" or speech, but when he had concluded, I did announce that henceforth Mr. Desjarlais would be expected to submit to questioning in the usual way.

Cultural considerations of this type are discussed in detail in the AJI Report, and in fact that report was referred to frequently at the inquest (and it was an excellent aid). I attempted to understand and accommodate cultural differences, while working within the existing system.

I will use the terms "aboriginal" and "Indian" in this report. The difficulty of deciding on terms to describe aboriginal people and groups was referred to in the Kimelman Report entitled "No Quiet Place", which is Exhibit 73(g). Terms such as "Indian", "aboriginal", "native", and "indigenous" have all been used to apply to aboriginal people and groups. However, there are difficulties with all of these terms. An example of a difficulty is found in a footnote on page i of the Kimelman Report where it is stated as follows:

> "The term "aboriginal" was used until this was objected to by Metis persons who view themselves as neither aboriginal nor European but as a unique cultural group combining characteristics of both. Therefore, for purposes of this report the term Indian is used when referring to persons who are entitled to be registered as Indians under the Indian Act. The term Metis is used to refer to individuals who have Indian ancestry but are not entitled to be registered as Indians. The term Native is used when referring to Indians, non-status Indians, and Metis persons collectively. The capitalized N is used intentionally to differentiate between persons with Indian ancestry and native Canadians who are persons of any ancestry born in Canada."

I will use a more simplified system when referring to aboriginal people and groups in this report. Generally, where a specific term is necessary I will use "Indian". For example, I will refer to "the Indian leadership". Where a more general term is required, I will use the term "aboriginal". For example, I will refer to "aboriginal

children", or "the aboriginal community". I will not use the term "native" unless that term is found in a quote. It is my opinion that the term "native" lacks a clear meaning. For example, although I was born in Manitoba and have lived here for all of my life, and hence I am correctly described as being a "native of Manitoba" and, a "native born Canadian" I am neither an aboriginal person nor an Indian. The term "indigenous" is better used to describe plants and animals than people and will not be used in this report unless it is included in a quote or a title. Although there are some difficulties as well with the terms "Indian and "aboriginal", these are the terms that will be used in this report.

A procedural problem not related to culture was the order of cross-examination. Counsel for DOCFS and Marion Glover both wanted to cross-examine last, and they both wanted to re-examine after the other had cross-examined. I decided that in the case of a witness suggested by counsel for DOCFS, Mr. Paterson would have the right to question last. In all other cases, if Mr. Paterson and Marion Glover were not able to agree on an order of cross-examination, they would simply have to take turns. There would be no right to re-examine after cross-examination by Marion Glover or Douglas Paterson (otherwise this could go on ad infinitum), but if the party who had cross-examined first had questions remaining after the other's cross-examination, the questions would be asked by the Crown (who of course

always has the right of re-examination). This was not a hard and fast rule, and in fact with some witnesses, if Marion Glover cross-examined last, and new matters prejudicial to DOCFS were raised by the cross-examination, I did allow Doug Paterson to question further (and vice-versa).

These rules were developed because of the dispute between Marion Glover and DOCFS, and the fact that Marion Glover was representing herself. I was concerned that to simply allow re-examination until exhaustion set in could exaggerate the movement of the inquest away from what it was to deal with, namely the circumstances surrounding the death of Lester Desjarlais, and the questions asked by the Chief Medical Examiner and Ombudsman, towards the fight between Marion Glover and DOCFS.

Many of the witnesses who testified at the inquest strayed into areas that were clearly not within the mandate of the inquest. Cecil Desjarlais and Ellen Cook spoke about aboriginal self-government. Personal grievances were aired. Because of the complexity of the matter, and the labyrinthine connections of one issue to another, I allowed witnesses to tell their stories with the minimum intervention. I was guided in this by the decision of Jewers, J. in the Swan inquest, (unreported, Suit No. CI 91.01.59159 Winnipeg Centre), as well as by the strong criticism of the inquest judge at the Harper inquest (found in the Aboriginal Justice Inquiry Report) for not giving the

parties sufficient latitude in investigating issues. The lesson I drew from both of these precedents (although technically the AJI report is not a precedent) was that it is better to err on the side of allowing too much in, than to err on the side of not allowing in relevant evidence.

After hearing Marion Glover's evidence it was clear to me that I would have to deal with issues much wider in scope than a boy's death at this inquest. It would have been extremely helpful to have a mechanism that would allow for the adjournment of an inquest under these circumstances in order to obtain further instructions. Was it my assignment to inquire into the broad areas opened up by Marion Glover's evidence, or were those matters to be dealt with in a different forum? I recommend that the government examine this issue in relation to The Fatal Inquiries Act to assist judges in future cases.

This report will attempt to deal with the question set out above. Because of the many issues raised in attempting to answer the question, items far beyond the immediate death have been discussed. Some of the issues raised are relevant, and some are not relevant, or only marginally relevant. Before reporting on the matters considered relevant, I will set out below some matters I do not consider relevant to this report. I do so because they were raised at the inquest, and I want to make clear what the inquest is not about.

This inquest is not about aboriginal self-government.

This inquest is not about the women's movement within the Indian community. Some of the witnesses, notably Ellen Cook, and Joyce Wasicuna, spoke eloquently about the need for aboriginal women to become more involved at all levels, and in every way, within the Indian community - to begin tackling the horrendous problems that exist on reserves and within the Indian community generally. They point to what seems like overwhelming male domination on the one hand, and the deeply entrenched problems of violence within the family, sexual abuse, and alcohol abuse, and ask how these problems can possibly be addressed until aboriginal women become involved and empowered at all levels.

Witnesses made thoughtful comments about the current male Indian leaders. It was noted that many of these men are the products of residential schools. They have unresolved problems, and their anger and denial interfere with their ability to deal with the gigantic social problems plaguing their communities.

Dr. Art Blue, an aboriginal psychologist who testified at the inquest, made some fascinating comments in this regard. According to Dr. Blue, many of the social decisions that were formerly made by women within the traditional Indian community have now been taken over by chiefs, councillors, and other males in official positions. This is something new for the men, and it may help to explain why chiefs and councillors are having such a difficult time making appropriate decisions. It was suggested to Dr. Blue

that the present movement by Indian women becoming more involved within the Indian community is in fact a return to the way things were done in times past. Dr. Blue agreed with this suggestion, and added that in his opinion the movement by Indian women to become more involved was well on its way.

Isaac Beaulieu and Dr. Charles Ferguson also added their voices to this discussion, and of course the AJI Report devotes an entire chapter (Exhibit 13 page 475) to this very important subject.

These arguments are very compelling. However, they are obviously being discussed within the Indian community, and generally, and an inquest such as this one cannot deal in a satisfactory way with such a complex issue.

Similarly, this inquest is not an inquiry into the general state of the child welfare system in Manitoba, or what has been called the Indian or aboriginal child welfare system. These subjects will be discussed only to the extent necessary to explain the issues.

The "lack of resources" issue was not dealt with at all at this inquest. It is recognized that child welfare agencies need money to operate, and that this money comes by and large from monies collected by government. In the case of Indian child welfare agencies, the funding government is the federal government. The area is a complicated one, and cannot be dealt with at a hearing of this type. When "resources" or "lack of resources" (which is modern day

terminology for "monies collected by governments") was mentioned, I intervened and restricted counsel from pursuing these questions.

Similarly the whole issue of aboriginal people and economic dependence was touched on fleetingly only at this inquest, and I will not comment on that topic in this report.

There are many other issues raised in one way or another by various witnesses that will similarly not be reported on. The political system existing on reserves, and on Sandy Bay, is not the business of this inquiry and no comments will be offered on the subject. The recognition given to aboriginal people by the child welfare system in Manitoba is also not the business of this inquest. That is clearly the business of the Province and the Indian community. The report from this inquest will limit itself as much as possible to the questions submitted by the Chief Medical Examiner and the Ombudsman.

Although this is clearly not a general public inquiry, it has evolved into something more than a routine inquiry into the circumstances surrounding the death of a person. Lester Desjarlais hanged himself. A beautiful child dead - a life wasted. There is no tragedy greater than a child dying. But for worldly purposes, Lester's suicide would have gone virtually unnoticed by everyone except his family and friends. The actual death itself was clearly a suicide, and though tragic in the extreme, was unremarkable. Were it

not for the missing files, the allegations made by Marion Glover, and the other questions asked of this inquest, an inquest would have been concluded quickly, and a short report would have issued. But the peculiar facts of this case and the way they developed have given Lester's short life an importance that it would not otherwise have had. His suicide and its aftermath have made it necessary to closely examine the operation and structure of DOCFS, and come to terms with larger issues as well.

It only became clear to me after listening to Marion Glover , Elaine Scott, Esther Seidl and John Chudzik that I would have to do this. It occurred to me then that I might not be the most appropriate judge to perform this task. As a provincial court judge with family jurisdiction I had heard DOCFS child protection cases since the agency was formed until the transfer of child welfare jurisdiction to the Court of Queen's Bench in Brandon (as indeed I heard protection cases from other child care agencies during that time, most notably from Child and Family Services of Western Manitoba.) In fact I had attempted to promote the formation of a local child welfare committee in Brandon by DOCFS for urban aboriginal residents at one time (with no success.) So I was concerned that as I had a connection with DOCFS, and with child welfare work in the western area, a judge from outside of the area might be a more appropriate choice.

However, by the time these concerns became evident, the inquest was well on its way. The practical considerations,

and the fact that every provincial court judge has some work involvement with a child care agency led me to the conclusion that while had the issues been clear at the outset, I might have asked that another judge take this inquest, I should continue with it now that it was underway. But I will state a bias that I held when I heard child protection cases, and that I have today - namely this: aboriginal people should be able to fully participate in, and manage, matters that vitally affect their communities, and child welfare is one of those matters.

A total of sixty-two witnesses testified at this inquest over a total of approximately forty full hearing days. It was not possible to schedule these days in uninterrupted succession for a number of reasons including the inadequacy of court facilities in Brandon. The issues are complicated and my report is lengthy. I have attempted to make the report as clear and easy to read as possible, and I have included a list of witnesses, with very brief descriptions where necessary, at the end of this report as an aid to the reader.

This report will begin with an examination of the concerns of the Office of the Chief Medical Examiner and the concerns of Ombudsman Manitoba.

## PART I -CONCERNS OF THE OFFICE OF THE CHIEF MEDICAL EXAMINER

### A ."CLEAR THE AIR REGARDING THE CIRCUMSTANCES THAT LED TO THIS UNTIMELY DEATH:"

Lester's short life was one of chaos and impermanence. It is said that he came from what is commonly termed a dysfunctional home, but in reality Lester had no home at all. His mother, the late Joyce Desjarlais, was a hopeless alcoholic, who was incapable of providing even the minimum acceptable standard of care for her children. Although the missing DOCFS files make it impossible to properly chronicle the life of Lester Desjarlais, it is very clear from the available evidence that Lester never had a chance.

Even before the creation of DOCFS in 1982, the Children's Aid Society of Eastern Manitoba (Portage la Prairie) were doing crisis intervention work with the Joyce Desjarlais family. Because of Joyce Desjarlais's serious personal problems, she was not able to provide a home for any of her children and all attempts to reunite the family ended in failure.

Joyce Desjarlais drifted from reserve to city, and back again, and went from one relationship to another. Whenever Joyce Desjarlais was near her son, any gains that foster parents had been able to make with Lester were quickly lost. Joyce's life of chaos and instability followed her like a cloud, and enveloped Lester whenever he came near. Mother

and son loved each other; that can't be doubted. Lester wore tattoos that said "Joyce loves Lester - Lester loves Joyce." Joyce Desjarlais, for all her faults, was Lester's mother, and Lester had bonded with her. However, that is all that Joyce could offer Lester. It is a tragedy that she did not let him go permanently, when he was still young enough to overcome the harm she did to him. Joyce Desjarlais survived her son by only six months. She died on October 25, 1988.

Lester's natural father was Norman Anderson (now deceased). Isaac Beaulieu described Mr. Anderson as a Cree Indian from the interlake area of Manitoba. According to Mr. Beaulieu, Mr. Anderson was an abusive man who drank excessively and assaulted Joyce Desjarlais. And Dr. Charles Ferguson of The Child Protection Centre shuddered when Norman Anderson's name was mentioned to him. The Norman Anderson Dr. Ferguson knew was a person with morbidly serious personal problems. In fact there is evidence that Lester was assaulted on more than one occasion, and that he showed up at Health Sciences bleeding, explaining the his "step-father" had beaten him up.

Not a great deal is known about this part of Lester's life. I believe that I am safe in concluding that anything Norman Anderson "gave" Lester only contributed to the sadness in Lester's life. Norman Anderson survived his son by a few days only. He apparently committed suicide after learning of his son's death. This information was provided

by Lester's older sister, Sherri McIvor, who was the last witness to testify at this inquest.

None of the other men in Joyce's life (and there were many) helped Lester. Cecil Desjarlais was Joyce's husband before Lester was born. Those were his drinking days. He gave nothing to Lester in Lester's early life, and later on contributed to Lester's problems with his interference.

Some people on Sandy Bay tried to help. The home of Virginia and Arthur Roulette became a safe refuge for Lester. But, in general, the Sandy Bay community did not give him much support. Lester was described by Marion Glover as being like a "stray animal" in the Sandy Bay community. For the most part, he wandered about without any supervision. Very often he was not attending school at all, and even while he was a ward of DOCFS there were long stretches of time when no one from DOCFS did anything for him.

Marion Glover was not the only person who described Lester in these terms. Angela Eastman, the vice-principal of the school Lester attended, described Lester as being "kind of on his own", and said that his transciency, and the instability in his life, were the main reasons why Lester did not do well at school. Constable Al Miller of the DOTC Police said that Lester "kind of floated around between residences". Constable Miller said that when members of the police force attended at the home of Joyce Desjarlais, she was usually drunk, and Constable Miller gave his opinion as

a police officer that Joyce Desjarlais was a chronic alcoholic. Constable Miller also said that Lester had a serious problem of drinking and sniffing solvents for a boy of Lester's age. The police had occasion to deal with Lester on a number of occasions for break-ins, and on one occasion Constable Miller had to lock up Lester, then not even a teenager, under the Intoxicated Persons Detention Act. It is clear from the evidence that Lester's problems as an adolescent were very serious.

But DOCFS did not seem to take them very seriously. Again, although Lester's files are missing, and all of the involvement with Lester by DOCFS will never be known, it is clear that from the time when DOCFS became responsible for child welfare matters on Sandy Bay, namely in 1982, Lester was one of their cases. He would live with his aunt Audrey, or his grandfather, Alex, and sometimes with his mother. The home of Virginia and Arthur Roulette was also a place where Lester would stay. But there did not appear to be any permanent plan for Lester, and from the limited material available, it appears that the agency would intervene only when there was some type of crisis. Short term plans would be made. The placement would disintegrate. The pattern would be repeated. In the meantime Lester was growing older; he was getting into trouble with the law; he was sniffing gasoline, and taking any other substances that were available; no one was taking responsibility for him. (Elaine Scott of DOCFS testified that Lester had as many as

nine placements in one year). In short, Lester was careening crazily from one temporary home to another, with virtually no direction or supervision from anyone. DOCFS planning was ad hoc and slapdash. There was no long-term plan for Lester

Now, it is important to distinguish between the way Lester was living, and the way some aboriginal children live within the extended family. Evidence was given at the inquest concerning the extended family, a concept that is now quite well understood by the non-aboriginal child care community. Within traditional aboriginal families the concept of the nuclear family is foreign. A sister, grandmother, or aunt and uncle may have the same feeling of responsibility for a child as the biological mother and father. It is not at all uncommon, and in fact quite normal, for a child to live a part or all of his or her childhood with a relative who is not that child's biological mother or father. For instance, if a mother gives birth to a child when she is very young, the mother and her older sister may agree that the child should be brought up in the home of the older sister. Ellen Cook, an aboriginal social activist, explained to the inquest how a woman will be considered a grandmother when her sister has a grandchild. The concept of the extended family is quite different from the understanding that modern urbanized society has of the term "family". (It is probable that the concept would have been less foreign one hundred years ago,

and even now may be more easily understood in a rural area than in an urban area.)

In any event, the concept of the extended family was outlined in detail at the inquest, and it was explained how DOCFS incorporates this concept into the way DOCFS workers do their jobs. What might appear to the non-aboriginal community to be a disorganized, or chaotic method of child care, may be perfectly acceptable to the aboriginal community when the concept of the extended family is taken into account.

Isaac Beaulieu gave an example of Indian families attending a pow wow. Children are all over the place, and to a non-Indian it would appear that the parents are not looking after their children. But in fact uncles and aunties would be watching out for the children, and the children would be every bit as safe as non-aboriginal children at a fair.

It was explained by witnesses how a child on the reserve might go to live with an aunt for a week or a month, and might then return home, and all of this would be considered perfectly normal to members of the family. The same thing might be considered unacceptable, and grounds for intervention by a child care agency, if it occurred within the non-aboriginal community.

But that is not how Lester lived his life.

The method of child rearing within the extended family assumes a number of things. First, the members of the

family always have the welfare of the child as their paramount consideration. Members of the family, for instance the young mother and the older sister, will agree that the child should live with the older sister, and the important thing here is that the mother knows that the child is with the older sister, and knows that the child will be looked after. It is not strictly necessary that the mother knows exactly where the child is living, or what the child is doing. The mother knows that the older sister is responsible, and will look after the child. But with Lester, there are periods of time when no one was looking after him. He was truly on his own. His mother was simply overwhelmed by her own problems, and was unable to protect Lester.

Other members of the family, or members of the community, offered a home to Lester for periods of time, but those placements always broke down. DOCFS was forced to intervene in crisis situations when it was clear that there was no other alternative.

For reasons that are not clear, Lester was not properly protected and cared for at Sandy Bay. Joyce couldn't, Virginia and Arthur Roulette tried, but their home was a temporary refuge only. Other Desjarlais family members assisted temporarily. But there was no one family person that took primary responsibility for Lester.

So, although the concept of the extended family has been explained to the inquest, it is of very limited relevance in the case of Lester Desjarlais.

When DOCFS did intervene, their efforts were halfhearted and ineffectual. A startling example of this occurred in 1987. It was described by Marion Glover. Ms. Glover was originally hired by DOCFS in May of 1987 as a child abuse consultant. Part of her duties consisted of sitting in on DOCFS staff meetings that took place at the Brandon office every second Monday. In July, 1987, Ms. Glover was in attendance at one of the meetings, when it was reported by a co-ordinator of the Sioux Valley Group Home, where Lester had been placed, that Lester Desjarlais and another child had run away from the Sioux Valley Group Home. (Immediately prior to this placement, Lester had been at BMHC, and prior to that he had been at Seven Oaks. These placements appeared to be arranged on the spur of the moment, with no long term planning at all.) They had stolen bicycles, and apparently had pedalled all the way from Sioux Valley to Sandy Bay. The discussion at the meeting was one of amusement about the resourcefulness of Lester and the other absconding boy. No one at the meeting suggested that the children should be re-apprehended, and no plan was made for the children.

Ms. Glover was in attendance at the next staff meeting two weeks later when Lester's name came up again. At this time it was reported that Lester had broken into the Sandy

Bay School, and again there was no order given to DOCFS workers to re-apprehend the child, or any plan made for Lester's return to the Sioux Valley Group Home, or any other plan for him for that matter. The meeting concluded that Lester was probably with his mother, and that was it.

Marion Glover became a supervisor with responsibility for Sandy Bay in September of 1987. At that time Lester Desjarlais was still at large. He had not been re-apprehended, and it is my conclusion from the evidence that DOCFS simply assumed that Lester was living somewhere on the reserve and was getting by somehow and the agency took no action whatsoever.

Now, it has to be understood that Lester was a ward of DOCFS at the time. He was not simply a name on a protection file. It was the agency's responsibility to plan for their ward. Presumably, some type of plan had been arranged, because Lester had been placed at the Sioux Valley Group Home. At the very least, when it was first discovered that Lester had escaped from the group home, the agency should have immediately made arrangements to re-apprehend him. Whether or not Lester should have been returned to the group home, or placed in another home is not important. That is a decision that would have to have been made by the worker, in consultation with the supervisor, after having received input from the local child welfare committee. The point is that the agency knew that their ward had run away from the group home. He had been apprehended in the first place

because his mother had not been able to look after him. He was their responsibility, and they chose to let Lester fend for himself. This is truly shocking. It also must be noted that DOCFS offered no contradiction of Marion Glover's evidence on this point.

DOCFS suggests that there are "native ways" understood only by Indian people that make what to a non-Indian might appear negligence, perfectly acceptable to the aboriginal community. The inaction of DOCFS from the time of Lester's departure from Sioux Valley, until Marion Glover's intervention, cannot be explained in this way. It was negligence and incompetence pure and simple. It did not involve lower level employees only. It was discussed at the Brandon office. Morris Merrick and Ron Mousseau were primarily involved.

Marion Glover testified that within days of becoming a supervisor in September 1987 she received a call from Mr. James Boyd Waddell (more about Mr. Waddell later). Mr. Waddell told Marion Glover that Lester was in his office, and that Lester had been burning himself with cigarettes. Mr. Waddell expressed concern for Lester's safety, and wondered why no one was doing anything about the child. Mr. Waddell knew that Lester was a ward of DOCFS. It was Marion Glover who contacted DOTC Police and instructed them to pick Lester up and bring him to the Brandon Mental Health Centre. That was done. This was Lester's second admission to BMHC, the first taking place before Marion Glover became involved

in Lester's case. This incident marked the beginning of Marion Glover's involvement with Lester Desjarlais.

The Brandon Mental Health Centre, or BMHC, plays an important part in the last year of Lester's life. Whereas the Seven Oaks Centre was used mainly as a dumping place for Lester by DOCFS, and nothing significant was done for Lester at Seven Oaks, BMHC tried to help, but were prevented from doing so by DOCFS and the Sandy Bay community. I will spend some time detailing BMHC's involvement with Lester.

Lester had three admissions to the Brandon Mental Health Centre in total. The first was from May 12 to May 22, 1987, the second was from September 18 - October 14, 1987, and the third was from January 21 - February 11, 1988. Marion Glover was involved with the second and third admission, but had no involvement with the first admission. On the first occasion, that is prior to Marion Glover's involvement with Lester, it is clear that DOCFS signed Lester out before the hospital investigation was completed.

Elizabeth McLeod, a psychiatric social worker with BMHC, was one of the mental health personnel who dealt with Lester on all three admissions. She explained that although most adolescents come in as non-compulsory patients, that is they are signed in by their parents or guardian, Lester came in as a compulsory admission. Dr. Macklem of Gladstone had given his opinion that Lester was a danger to himself or others in all three cases.

Mrs. McLeod explained that the process after admission is to set a date for a diagnostic meeting, involving the multi-disciplinary team, so that plans can be made for the child. The multi-disciplinary team consists of nursing staff, psychologist, medical doctor, psychiatric social worker, and the guardians, (if the child is a ward of an agency.) The nursing assessment is read out. The nurse makes recommendations about nursing. The social worker then contributes. The social worker has by that time interviewed the family whenever possible, and other social workers, perhaps probation officers and other service providers that may have been involved with the child. The psychologist and medical doctor then give reports about the child. A fourteen page questionnaire completed by the adolescent that includes questions about suicide is a part of this process. (Elizabeth McLeod explained that in many cases involving admission of adolescents to BMHC, suicide is a definite concern). After all of these reports have been submitted the outside agencies, including the representative of child caring agencies involved, are invited to give opinions.

Following Lester's first admission on May 12, 1987, Elizabeth McLeod estimated that she would have spent about three or four hours with Lester in total preparing for the conference, and another two hours with Lester after the conference and before his discharge on May 22, 1987. On the second and third admission, Elizabeth McLeod would not have had to spend that much time with Lester because she had

obtained much of the information she needed following his first admission. But it is fair to say that Elizabeth McLeod had a good opportunity to form an assessment of Lester's needs, and was quite familiar with his case.

The diagnosis following the first diagnostic meeting was "solvent abuse." Elizabeth McLeod explained that a solvent abuse program is offered at BMHC for adolescents, and it consists of inpatient care over a number of weeks. The medical report given at the diagnostic meeting indicated that Lester had an elevated lead level in his blood, indicating gas sniffing. Lester was a candidate for this program.

Before BMHC had an opportunity to do any work with Lester, DOCFS and parents signed Lester out. This was against the advice of BMHC.

On the second admission, that is on September 18, 1987, Marion Glover was at BMHC as Lester's worker. From Elizabeth McLeod's perspective much the same thing happened after this admission. Namely, a diagnostic meeting was held, plans were made, and Lester was signed out by DOCFS against the advice of BMHC, before any treatment could be attempted.

The additional portion of the diagnosis on this occasion included the concern that Lester may have been sexually abused. This information had been provided to BMHC by Marion Glover. It consisted of Marion Glover's statement that Lester had confided to her that Joe Desjarlais,

nicknamed Peance, had tied him to a tree (or post), and may have sexually abused Lester. (The same disclosure Lester later made in its complete form to Angela Eastman, the vice-principal of the Sandy Bay School, and shortly before his death to foster parent Angus Starr.) Lester had not yet told Marion Glover that Joe Desjarlais had anally raped him when he was tied to the tree. He had hinted at it, but Lester would then tell Glover that he had escaped before being molested, or that his older brothers had beaten Joe up before anything happened. It was not until sometime in January, 1988, that Lester told Marion Glover in a direct way that after Joe Desjarlais tied him to a tree he anally raped him. So the fact that BMHC gave priority to Lester's other serious problems, as opposed to his possible sexual abuse is quite understandable. The sexual abuse was a partial disclosure only at that stage.

There was conflict between Marion Glover and BMHC during the time of this admission. For one thing, Marion Glover was questioning the way BMHC was handling Lester's case. (It was also on this occasion that Elizabeth McLeod formed the distinct impression that Marion Glover had said or implied that she, Marion Glover, had a Master's Degree in Social Work). Elizabeth McLeod assumed that Marion Glover was in agreement that Lester should be removed from BMHC and returned to the reserve. In fact, there is other evidence to indicate that this was not the case. Marion Glover was not the person who was pushing for Lester's removal.

Rather, the impetus was coming from people on the reserve. Lester was again taken from BMHC before any treatment could be attempted. Marion Glover's performance as supervisor at this stage was amateurish. DOCFS did agree that if Lester's placement after his premature discharge from BMHC broke down he was to be returned to BMHC.

It cannot be said that BMHC could have brought about a significant change in Lester's life. He was so damaged, and his life was so crazy by that point that it is perfectly conceivable that BMHC's attempts to help Lester would have ended in failure. But the point is that BMHC was not given the chance to help. Lester was removed from BMHC prematurely on both occasions before treatment could be attempted. DOCFS was the agency responsible for Lester. They must accept the blame. At the time of the first premature discharge Marion Glover was not involved. At the time of the second she was the supervisor responsible for Lester.

The placement Marion Glover arranged for Lester following his discharge from BMHC on October 14, 1987 was at the home of Arthur and Virginia Roulette. The Roulettes are related to Lester, and Lester had lived with them for periods of time before. Lester revered Arthur Roulette. Mr. Roulette is a medicine man, and Lester wanted to follow in his footsteps. The placement did not last long, but it was an appropriate placement. As is typical with children who have gone from one placement to another too many times

there was a honeymoon period, and then the placement broke down.

From the time of Marion Glover's first contact with Lester Desjarlais until the time of his death, Lester's life continued to be extremely chaotic. It was after Lester's placement at the Roulette's broke down that what had been merely a sad, chaotic and unstable life became a true hell.

Lester's placement at the Roulette's broke down in the fall of 1987 because Joyce, true to her usual pattern, came to the home drunk and told Lester she was going back, once again, to Winnipeg. Lester completely lost control when he saw his mother in a drunken condition. He went to the home of his grandfather, Alex McIvor, and took a rifle from the home. He was later found shooting in a random fashion around the reserve. The placement at the Roulette's was at an end.

But instead of taking Lester back to BMHC, Ron Mousseau had him admitted to Seven Oaks. In truth this was not a placement. Ron Mousseau "dumped" Lester at Seven Oaks. He gave no reason for this incredible decision at this inquest, and pretended instead that he had almost nothing to do with Lester's case.

Seven Oaks is not a treatment facility. It is meant to be used for short term stays for troubled young people. But for reasons that have not been explained Ron Mousseau and Danta Kunzman kept Lester there for long periods of time. The records at Seven Oaks (Exhibit 12) make it clear that

Seven Oaks was not being used as an emergency placement. It was being used as some type of Winnipeg group home. While he was at Seven Oaks he was often signed out by Danta Kunzman, or was in fact on the run from the facility. I will not repeat here the almost comic dispute between Marion Glover with head office on one side, and Danta Kunzman, Ron Mousseau, Bill Richard and Cecil Desjarlais on the other side, with one side placing Lester, and the other side fetching Lester. It is sufficient to say that this "placement" of Lester was extremely inappropriate and unprofessional.

The Seven Oaks placement made even less sense when it is remembered that it was completely contrary to the plans that DOCFS and BMHC had endorsed for Lester. It was agreed when Lester was discharged prematurely from BMHC for the second time that if the placement at the Roulette's home broke down, Lester would be returned to BMHC for treatment before any other placement was considered. The Cecil Desjarlais, Danta Kunzman, Ron Mousseau, Bill Richard cabal was acting in direct opposition to this clear plan, and for reasons that are known only to them. Joyce's home in Winnipeg was completely unsuitable for Lester. This period of Lester's life, which consisted of "visits" to Joyce's home, returns to Seven Oaks after violent drunken arguments, and infighting by his "caregivers" was truly awful. The agency that was supposed to be protecting the boy was compounding his agony. From the time that Lester left the

Roulette home until his third and final admission to BMHC, I agree with Marion Glover that the "inmates were running the asylum". The functioning, or lack of it, by DOCFS at this stage was a joke. But the joke was on Lester.

This period of anarchy came to an end in January 1988 when Lester was returned to Sandy Bay. He was placed at Claudia Houle's foster home, and immediately returned to his typical Sandy Bay destructive behaviour. Marion Glover was called in, and found Lester in bad shape. He had been drinking and sniffing, and was very upset. Glover called the DOTC police in to help, and they took Lester to see Dr. Macklem in Gladstone. Lester ran from the doctor's office, and only after tracking dogs were brought in did the police manage to find Lester. The search took hours, and it was a cold January day. It is fortunate that Lester did not freeze to death. The incident caused Marion Glover to decide that she would return Lester to BMHC in spite of opposition from the group lead by Cecil Desjarlais.

It was during this time that Lester made his disclosure to Marion Glover about sexual abuse by Joe Desjarlais. He finally admitted that Joe Desjarlais had anally raped him after tying him to the tree. It was also during this time that Lester told Marion Glover about the pedophile, James Waddell.

Lester was an extremely disturbed and damaged child. His life was a hell. It should have been clear to everyone concerned that Lester needed much more than simple foster

placement. He needed immediate intensive help. He did not receive it.

Lester's third and final admission to BMHC was on January 21, 1988. He was discharged on February 11, 1988. The discharge on February 11, 1988, was not against the advice of BMHC. There was some joint planning involved, and what I would term reluctant agreement by BMHC to discharge Lester, as long as Lester was placed in a suitable foster home, and therapy for sexual abuse was offered.

BMHC's prognosis for Lester was "very poor". Elizabeth McLeod's assessment was that Lester had a very chaotic and unstable history. More alarming still, during his last admission, there were indications that Lester was less and less stable all the time.

BMHC was firm in their belief that Lester should not return to the reserve. Elizabeth McLeod agreed that by the time of the third admission, Lester's life was almost out of control. BMHC attempted to help Lester. Whether or not they would have been able to do anything for him will never be known. Lester's problems by this time were so severe that any help would be "damage control" more than anything else. But the point is that BMHC was not given the opportunity to help, because Lester was removed prematurely from the hospital on the first two admissions. On the last admission it is my impression that BMHC would have preferred to have Lester remain with them for some time, or to be introduced gradually to a foster home, but because of the

two previous premature signouts, they very reluctantly agreed to DOCFS plans for Lester's foster placement. In Lester's case, BMHC was allowed to assess only, and that is very unfortunate.

It was after his discharge from the Brandon Mental Health Centre on February 11, 1988, that he was placed at what was to be his final placement with Angus and Lillian Starr.

DOCFS complains that Marion Glover mishandled Lester's case, and that if anyone is responsible for Lester's death it is Glover. They suggest that Lester should not have been removed from Sandy Bay, and that Marion Glover was responsible for the chaos in Lester's life.

This claim of DOCFS is without foundation. By the time Marion Glover appeared on the scene, Lester's life was already chaotic in the extreme. Lester had bounced around from one place to another for years, while technically being in the care of DOCFS for a good part of his life. When Marion Glover became supervisor, Lester had been placed away from the reserve at the Sioux Valley Group Home. This placement was made by workers other than Marion Glover. Immediately prior to that placement Lester had been admitted to the Brandon Mental Health Centre. These arrangements had also been made by workers other than Marion Glover. Lester had been removed from BMHC by DOCFS before any treatment could be offered. That was also done before Marion Glover became involved. So the claim of DOCFS that Lester should

not have been placed away from the reserve is an unusual one. Every other type of reserve placement had been used by DOCFS for Lester before Marion Glover became involved, and they had all broken down.

In fact, the decisions made by Marion Glover for Lester after she became supervisor appear to be reasonable. She assumed conduct of Lester's file at a time when DOCFS appeared to be doing nothing for their ward. Lester absconded from the Sioux Valley Group Home. Morris Merrick and the DOCFS workers knew this, but took no steps to re-apprehend their ward. They simply noted that Lester had returned to Sandy Bay - that he must be living with someone, and did nothing. Marion Glover took the first concrete step in Lester's case since his admission to the Sioux Valley Group Home. After being informed by James Waddell that Lester was mutilating himself at school, and that it was clear that no one was looking after him, Marion Glover arranged for Lester's admission to BMHC. This was an appropriate step. It was completely understandable that Marion Glover took a personal interest in Lester's case after that. The rest of DOCFS had neglected their ward. Marion Glover saw to it that he received attention.

Marion Glover should have done more, as Lester's supervisor, to resist pressure to have Lester discharged from BMHC prematurely in October, 1987. But her next decision, namely to place Lester in the home of Virginia and Arthur Roulette, was sound.

Arthur Roulette was respected and loved by Lester. Mr. Roulette was considered an Elder on the reserve. Lester regarded that home as a safe refuge. In my opinion this placement decision was entirely reasonable. It did not work, but that is not Glover's fault. By that time any foster placement was probably doomed to failure.

Lester's third and final admission to BMHC was also appropriate. This was the best that could be done given Lester's terrible problems. Marion Glover cannot be blamed for Lester's serious problems that had been acquired during a short lifetime of chaos and neglect.

Marion Glover's final decision in Lester's case, namely to place Lester at the home of Angus and Lillian Starr, was also an appropriate decision. The Starrs were aboriginal. They enjoyed a good reputation. BMHC had strongly recommended that Lester be placed away from Sandy Bay.

All in all, Marion Glover paid attention to Lester's case, which was an improvement over the previous state of affairs. She made decisions based on Lester's best interests. She at least tried to do something for Lester.

While she was trying to plan for Lester, she was meeting with not only opposition, but a virtual mutiny from fellow workers. Bill Richard, who was a child care worker supposedly answerable to Marion Glover, was sabotaging placements while Marion Glover was arranging them. It is clear that Cecil Desjarlais was either instructing or encouraging Bill Richard to do this. Glover would place

Lester. Richard would pick Lester up and place him elsewhere. This would have been farcical if it had not involved the life of a child.

Richard's and Danta Kunzman's assessment that the home of Joyce Desjarlais was stable is almost beyond belief. It is made even more incredible by Danta Kunzman's admission that she had not even looked at Joyce's file before making this assessment. Even if Richard believed that Glover's decisions were wrong about Lester, he had no business deliberately sabotaging his superior's placements. All this did was to make Lester's difficult life even more difficult.

In the final few weeks of Lester's life, Marion Glover could have put in place sexual abuse therapy for Lester. More serious, she should have made sure the Starrs were informed about Lester's suicidal behaviour, and that they were equipped to handle it. She will be criticized for this in this report. But until Lester's final discharge from BMHC, it is my opinion that the complaint of DOCFS that Marion Glover mishandled Lester's file is without foundation. Lester's file was mishandled by DOCFS, but not by Marion Glover.

There should have been a plan made for Lester by DOCFS long before his final placement. DOCFS made no such plan. By the time Marion Glover became involved with Lester, he was an extremely damaged child.

(i) CIRCUMSTANCES OF DEATH

Lester's death occurred at the home of Angus and Lillian Starr, which was located a few miles south of Brandon, Manitoba. Lester had been placed at that home approximately two weeks before by Marion Glover as the DOCFS supervisor for Lester. His guardians, Angus and Lillian Starr were licensed to provide foster care.

On March 6, 1988, Darlene Spence, an adult child of Angus and Lillian Starr, was preparing supper. She asked Lester to fetch some potatoes, and when Lester didn't return, Ms. Spence asked Maxine Starr, another daughter of Angus and Lillian Starr, to look for him. Maxine Starr found Lester hanging by a yellow rope. The rope was tied to an apparatus used to remove engines from vehicles. Maxine summoned help. Lester's body was cut down, and the authorities were called. He was dead.

There was evidence that Lester had been upset about a conversation he had with his mother by telephone shortly before the suicide. During that conversation, his mother had apparently told Lester that she had sold Lester's gun in order to buy liquor. The gun was one of Lester's few possessions, and was prized.

Lillian Starr testified that she had found a yellow noose, a couple of days after Lester came to her home. Lillian Starr told nobody about the noose, and instead hid it between the wall and the hot water tank of the room where

the potatoes were kept. That was almost certainly the noose that Lester used to hang himself.

Lillian Starr testified that she does not know why she did not tell anyone about the noose. But she did say that she had not been advised by anyone from DOCFS that Lester was suicidal. Lillian Starr and Angus Starr both testified that they had received no special training to deal with suicidal children at any time before or after they became licensed to operate a foster home by DOCFS. Mr. and Mrs. Starr both testified that while Lester lived in their home, they were not aware of any plans that had been made for Lester's education, or counselling. They had simply been advised that Lester would be living at their home and that was it. Lester was not attending school while he lived with them. To their knowledge, Lester was not receiving any counselling, sexual abuse counselling or otherwise, while he was at their home.

It is difficult to understand why Lillian Starr told nobody when she discovered the noose in her home. It would seem that even a person with no special training in dealing with suicidal children or with suicide prevention would connect the finding of the noose a couple of days after placement at their home of a troubled teenager, with a suicide concern. At the very least, Mrs. Starr should have told Liz Loane or Marion Glover about the incident.

Marion Glover offered a suggestion on this vexing question. It is her belief that aboriginal people generally

have a difficult time confronting unpleasant issues. When ugliness, like violence, alcohol abuse and suicide by their fellow aboriginals is raised, the tendency is to "pull the covers up over your head". Dr. Charles Ferguson made similar comments about denial in the aboriginal community, and particularly an inability by male Indian leaders to face those difficult problems and acknowledge responsibility for them. Denial will be discussed in more detail further on in this report.

Whatever the reason was for Lillian Starr's failure to tell somebody about the noose, that noose was almost certainly the same one that Lester used days later.

It must be borne in mind that the Starrs were not given much information about Lester when he first came to their home. In particular, the Starrs had not been advised that suicide was a definite concern with Lester. And the Starrs had not received any special training to deal with suicidal children.

When Marion Glover testified at this inquest last fall she said that as far as she knew no plans were made for Lester's education after he was placed with the Starrs. Liz Loane could offer no information about educational plans. In fact, Marion Glover had made plans for Lester's education prior to his placement with the Starrs. She did not remember these plans until the teacher DOCFS had hired to homeschool Lester at the Starrs approached her some time

after she gave her evidence in fall, and reminded her about it.

The teacher's name was Darrell Miller. The plans made were appropriate. Because Lester was so far behind in school, Mr. Miller would homeschool him at the Starrs until Lester was ready to enter an occupational entrance type of school program. Lester was not slow. In fact he was intellectually at least average. However, because of his chaotic life he had missed so much at school that there existed what Marion Glover described as an "educational gap" that had to be filled before Lester returned to a school.

The plans made for Lester's education were appropriate, but before Mr. Miller could begin work, Lester took his life.

In my opinion, DOCFS was responsible for both properly training their foster parents, and making sure that foster parents were advised about any special needs or concerns about children being placed in a foster home, and in particular any concern about suicide. Liz Loane was the off reserve worker, and she should have made sure that these matters were addressed. But her supervisor was Marion Glover, and Marion Glover must bear ultimate responsibility here. She had made it clear that she had a special relationship with Lester, and that she would be visiting with Lester, and assuming more than the usual supervisory role in Lester's case. In fact, Marion Glover had taken Lester home with her a number of times, and this was known

to Liz Loane. It is not unreasonable in this case for Liz Loane to claim that she had expected that Marion Glover would ensure that the Starrs were advised about the mental health concerns, and had information about how to deal with Lester. Even if Marion Glover had not taken such a special interest in Lester's case, she would, as the supervisor, be responsible for these matters. In this case, Marion Glover should either have given the Starrs this information directly, or she should have made sure that someone else properly briefed the Starrs. She did not do so.

This must be qualified by the almost hopeless confusion over role responsibility that existed within DOCFS (this will be dealt with in detail later in this report). In the case of the Marion Glover - Danta Kunzman dispute about Lester and Annette (an older sister of Lester's) it became evident that there was so much confusion within DOCFS about lines of authority and position responsibility that even the agency's lawyer, Vic Savino, did not understand who was to do what. Who was to be responsible for Lester after his placement at the Starr home is just one more example of the confusion within DOCFS.

In addition, there was no evidence offered by DOCFS that foster parents who are asked to take suicidal foster children have any special training in that area. I will recommend in this part that before a child who is considered suicidal or who has other special concerns is placed in a foster home, DOCFS ensure that the foster parents are

adequately briefed about that particular child and the concerns that exist, and that the foster parents generally have adequate training in fostering children.

The confusion within DOCFS, and the lack of training for all DOCFS personnel, including foster parents, was painfully evident throughout this final episode of Lester's life.

Evidence was offered at this inquest that the norm for child caring agencies is to insist that potential foster parents have extensive training before they are allowed to foster children. The training requirements are even more stringent when the child has special needs. The training offered for foster parents by DOCFS is practically nil. Mrs. Starr remembered a get together at Brandon's Friendship Centre, but remembered nothing about it. Angus Starr had no training at all. The belief of DOCFS seemed to be that because foster parents were aboriginal they somehow magically became competent foster parents. This is only one example of the fuzzy thinking of this agency, and contributed to the problems that became evident at this inquest.

Angus Starr's name was mentioned numerous times at the inquest. I will digress slightly at this point and mention the evidence that was volunteered at this inquest concerning a homosexual rape by Angus Starr sometime in the 1960's. Ralph Roulette, a police constable with the Ontario Provincial Police testified that Angus Starr had anal

intercourse with him by force at Sandy Bay. At the time, Angus Starr was a grown teenager, and Ralph Roulette was a younger boy. Ralph Roulette explained that this was the first time that he had made this disclosure, and that his life had been badly affected by this incident, and by the sexual abuse he suffered at residential school at Sandy Bay at the hands of the lay brothers working at the school.

Angus Starr was both taken aback and embarrassed by this evidence. He volunteered the suggestion that perhaps Ralph Roulette was confusing him with another Angus Starr, Angus Edward Starr who also lived at Sandy Bay at the time, and in any event he was not guilty of the rape. Ralph Roulette was adamant that it was Angus Joseph Starr who had raped him. And in fact Angus Edward Starr later appeared with counsel to formally deny that he had sexually assaulted Ralph Roulette. (It was and is clear to me that Ralph Roulette was referring to Angus Joseph Starr and not Angus Edward Starr).

Because Angus Joseph Starr was Lester's foster parent at the time of the suicide, I decided that I had to let this evidence in. There was no other evidence subsequent to the testimony of Ralph Roulette that was critical in any way of Angus Starr, apart from an injudicious decision he made as chief to request legal fees from DOCFS, and without commenting on the truthfulness of Ralph Roulette's account of rape, it is my conclusion that the home of Angus and

Lillian Starr was a good home, and that Angus Starr appeared to be a decent and capable person.

It should be noted that there can be no question that suicide had to be considered a concern with Lester Desjarlais. The Brandon Mental Health Centre records make it clear that suicide was a concern. Lester had spoken about suicide with a number of people, and he had exhibited self-destructive and suicidal behaviour (for instance, the self-mutilation at school, and the rifle incident), and all of this was known to DOCFS. When Marion Glover phoned Vic Savino, DOCFS's lawyer in Winnipeg, two days after Lester's death she told Mr. Savino "he said he was going to do it and he did". In the case of Lester Desjarlais, DOCFS knew that suicide was a concern.

Marion Glover describes a conversation with Lester when she was taking Lester to her home from BMHC for a weekend with her family. Lester brought up the subject of suicide. He said that in the white man's world, suicide was considered the act of a coward, but to an Indian, suicide was the act of a brave. (Lester was very much influenced by Indian spirituality - in fact he revered Arthur Roulette who was a medicine man and he aspired to be a medicine man himself when he grew up). When Marion Glover tried to discuss this further with Lester he changed the subject.

This is not to say that Lester was "suicidal" in the sense of a person inexorably driven to suicide by despair. BMHC gave their opinion that Lester was extremely impulsive.

His usual pattern was to act out after being disappointed by his mother. Under certain conditions, this combination could be fatal.

Lester was at the Starr home for a short time. It is not known when he decided to take his life. He left no suicide note. But it is clear that Lester had thought about suicide often before his final foster placement.

The history of Lester's life is incomplete. Lester's files are not available. But it cannot be assumed that the files would fill in all of the missing bits. The DOCFS files examined at this inquest are noteworthy for their skimpiness and lack of information, and Lester's file was probably no exception.

Before the time of Marion Glover's involvement in Lester's life, namely prior to the summer of 1987, Lester's life seemed to be much the same as it was after she became involved: frequent moves, no stability, and no plan. Lester's suicide, given the chaos in his life, should have come as no surprise.

I will add one disturbing thesis before concluding this part of my report. It is not capable of being proven, but the parts all fit. The basic parts of the thesis are put forward by Marion Glover. It goes as follows:

When Bill Richard testified, he described visiting at the Starr's home four days before Lester committed suicide. Now Bill Richard is a pleasant fellow, but as I will outline later in this report, he is completely unqualified to be a

child care worker. He does not know the first thing about social work, and relies completely on his knowledge of Sandy Bay, his aboriginal background, his "life experience" and his good intentions. Bill Richard talked with Lester and told Lester that soon he would be able to go back to Sandy Bay and be with his mother, Joyce. This would have been terribly confusing to Lester. Marion Glover and BMHC had worked hard to prepare Lester for the placement at the Starr home. Lester was reconciled to the plan. The short term plan was to have Lester stay at the Starr home and work on his main problems. A return to his mother's home was a long term plan, and would only come to pass if Joyce was able to solve her raging drinking problem, and the other serious personal problems that had plagued her for years. In any event, until Bill Richard came along, with talk of Lester returning to Joyce's home, Lester thought of that possibility as a long term dream. But no longer.

It is not unreasonable to assume that Bill Richard, again with the best of intentions, returned to Sandy Bay, and told Joyce that Lester would soon return to her.

Joyce, like many other hopeless alcoholics, wanted above all to remove herself from any situation involving the accepting of responsibility. And that was her pattern. When anyone tried to force responsibility on her, she would deliberately mess things up so badly that they wouldn't ask again for a long time. Whenever DOCFS suggested to her that

Lester could return to her home, she would create a crisis and the plan would be abandoned.

She didn't tell people that she was doing this. She would tell people that she wanted her children back. In fact, unqualified workers like Bill Richard would take her words at face value. (For reasons not clear to me, Danta Kunzman, an experienced and qualified worker, could not see this). Time and time again Lester's visits at Joyce's ended in some type of crisis. Lester would show up at casualty drunk and beaten up. Or Joyce would get completely drunk and create a scene.

So it is not unreasonable to surmise that this pattern repeated itself one last time. Bill Richard told Joyce that Lester would soon be coming home to her. Joyce told Bill Richard that this pleased her. Bill Richard believed her. Joyce phoned Lester and told Lester she had hawked his gun for booze. Joyce knew how much the gun meant to Lester. She knew how upset her drinking made him. Joyce fully expected that this would end the talk about Lester coming home. What she didn't realize was that Lester's despair would be so deep that he would choose to end his life.

I believe that this thesis is correct. It is a dramatic example of many things, and for the purpose of this report, it demonstrates how important it is to have professional social workers dealing with these complex problems. DOCFS does not have them. I will discuss this urgent problem in detail later in this report.

This ends the "circumstances" portion of this report, but before moving on to the Inquest Review Committee's second question, I will examine the history of the dispute between DOCFS and Marion Glover. This dispute is an essential part of Lester's story.

(ii) THE DISPUTE BETWEEN DOCFS AND MARION GLOVER

This inquest concerns the death of Lester Desjarlais, and not the dispute between DOCFS and Marion Glover. And yet, an examination of the dispute is unavoidable if the issues that emerged at this inquest are to be understood. I will describe below, as briefly as is possible, the history of Marion Glover's employment with DOCFS, that began with a hopeful contract, and ended with the Executive Director of DOTC, Ernie Daniels, telling Marion Glover that he would "kick her fucking white ass all over the place".

Marion Glover was initially hired by DOCFS in May, 1987, on a three month, short term contract, as a child abuse consultant. The Executive Director of DOCFS at the time, Esther Seidl, interviewed Marion Glover, and recommended that she be hired. It was known to DOCFS that Marion Glover did not hold a degree of any kind, and that her former employment with Child and Family Services of Western Manitoba, as a child care worker, had been terminated because Marion Glover had misrepresented herself. Specifically, she had told Child and Family Services of Western Manitoba that she had a degree when she had none.

When a supervisor's position became available at Sandy Bay and Dakota Plains Reserves, she was asked by DOCFS to take the position, and she agreed. Again, it was known to DOCFS that Marion Glover did not hold a university degree, or even a community college diploma, when they hired her as supervisor. All of her training consisted of experience

obtained on the job, and private practise work with sexual abuse victims.

It is clear from the evidence given at the inquest by Bruce Fraser, a former Executive Director of Child and Family Services of Western Manitoba, that Marion Glover would not have been hired as a supervisor with his agency, nor would she have been hired as a child care worker, if she had been truthful about her educational background. There was also evidence that that would probably be the case across Canada. That is, a supervisor would have to have, at the very least, a Bachelor of Social Work and related experience, and a person without those qualifications would not be considered for a senior position such as supervisor.

And yet, Marion Glover appeared to be considered a "catch" by the agency. She was better trained than most other people working at the agency. The opinion will be given later in this report that the qualifications and training of DOCFS child care workers, and particularly supervisors, is far too low. This is a glaring example of that shortcoming. Marion Glover was not qualified for the supervisor's position, according to Canadian standards, but within DOCFS, she was considered better trained than others. Elaine Scott, who herself has been a supervisor and child abuse co-ordinator with DOCFS, looked up to Marion Glover as "someone she could learn from". That appears to be the way most others within DOCFS looked at Marion Glover, when she was hired.

In her words, Marion Glover always had a "poisoned relationship" with Morris Merrick, the present Executive Director of DOCFS, and then assistant to Esther Seidl. However, the evidence indicates that, at least initially, Marion Glover was fairly well regarded by her co-workers and other people at the agency (Danta Kunzman being an obvious exception).

Evidence from present employees from DOCFS carries a common theme - Marion Glover was incompetent and disorganized, and it was the confusion she caused that resulted in any mishandling of files by DOCFS at Sandy Bay. But that is not the way former employees of DOCFS, current employees Ella McKay and Bev Flett, and other responsible people at Sandy Bay remember it. People like Angela Eastman, Vice-Principal of Sandy Bay Elementary School, and Cst. Al Miller of DOTC Police, spoke of Marion Glover as a dedicated child care worker, with the best interests of the children she was to serve at heart. Angela Eastman and Cst. Miller are both completely credible witnesses.

Ella McKay and Bev Flett, two senior DOCFS employees, who came forward at the tail end of this inquest to describe an agency that was hopelessly confused, dominated by politics, and unable to protect children, confirmed this picture of Marion Glover as a capable and dedicated worker. They both gave their opinions that DOCFS had used Marion Glover as a scapegoat to deny and hide the serious problems

within DOCFS. Ella McKay and Bev Flett are also absolutely honest and trustworthy witnesses.

This is not to say that the DOCFS complaint that Marion Glover was disorganized, and that she caused a great deal of friction in the community, was without merit. There are plenty of examples that this was the case. (In my opinion, some of this was caused by the fact that Marion Glover simply did not have the necessary skill and training to be in a supervisor's position). However, most of the bad feeling generated within Sandy Bay, and within DOCFS, by Marion Glover came about as a result of her insistence that sexual abuse cases be thoroughly investigated. Marion Glover was responsible for exposing the problems, not causing them.

Although this inquest is not equipped or mandated to thoroughly inquire into the situation of sexual abuse cases on the Sandy Bay Reserve, it is clear from police evidence, as well as from Marion Glover's testimony, that not only was there a serious problem of sexual abuse on Sandy Bay Reserve, but even more disturbing, there was a tendency by some powerful reserve members, such as Cecil Desjarlais, to prevent these cases from being fully investigated and prosecuted. Marion Glover was "rocking the boat" and many people did not like it. That was the main reason why Marion Glover's relationship with Sandy Bay and the DOCFS head office became very rocky.

As the witnesses described the problem of sexual abuse at Sandy Bay and the difficulties involved in dealing with the problem a clear pattern emerged.

When sexual abuse allegations did come to light the police would do an investigation. Most often criminal charges would not be laid because witnesses recanted. If charges were laid, convictions would very seldom be obtained. The response of the Sandy Bay community in general seemed to be to work against having even the most serious sexual incidents exposed outside of the community. Pressure came from people within Sandy Bay to keep these matters in the community, and as a result the police reports simply collected dust on files. The overwhelming majority of the sexual abuse disclosures that were made did not even make it to the starting line of the legal system's gauntlet confronting children and adults who allege sexual crimes.

It is impossible to tell how many sexual abuse victims at Sandy Bay and other reserves do not make disclosures. I suspect that the actual disclosures represent the "tip of the iceberg" only. That is a phrase that was used by more than one witness at the inquest in precisely this context. However, the experience of Marion Glover and Joyce Wasicuna on this subject is enlightening. Both women worked at reserves (albeit different reserves) and both women were involved with child abuse cases. In fact both women were skilled in child abuse matters generally. Marion Glover said that when she began to deal with child sexual abuse

cases at Sandy Bay her caseload "mushroomed" almost overnight. One disclosure would lead to another, and then another. Late night telephone confessions and secret conversations would take place. Within one year of Marion Glover becoming the Sandy Bay supervisor, the number of sexual abuse cases had more than doubled.

Joyce Wasicuna testified that she had never met Marion Glover prior to the inquest, and she had never spoken to her. But her testimony was virtually identical on this point to the testimony of Marion Glover. Joyce Wasicuna was hired by DOCFS as a protection worker, and she took the job seriously. She is a skilled, intelligent woman, and this report will contain many references to Mrs. Wasicuna. Almost immediately after Joyce Wasicuna successfully completed her first child sexual abuse case (the perpetrator was convicted and sentenced in criminal court) she was almost inundated with sexual abuse disclosures. I will deal in a subsequent chapter with the general responses of the communities where Mrs. Wasicuna worked (Sioux Valley Reserve and Birdtail Sioux Reserve) which was to try and stop further investigations, to the point where Mrs. Wasicuna was literally driven off the Sioux Valley Reserve. At this juncture I will confine myself to noting the similarities between the evidence of Marion Glover and Joyce Wasicuna on this subject. In both cases once one disclosure was made, and it became apparent to victims that competent, caring

people were there for them, other victims came forward and the sexual abuse disclosure numbers skyrocketed.

Evidence was tendered at the inquest to explain this phenomenon. For one thing, victims will not disclose unless they are reasonably certain that they will be listened to. Their worst fear is not being believed. This is made even more difficult in a reserve community, where not only does everyone know each other, but the child welfare worker may well be related to the perpetrator. Marion Glover and Joyce Wasicuna were not preoccupied with sexual abuse - they were good at their job. I will not pursue this topic here, but the similar evidence of Joyce Wasicuna and Marion Glover is important for a number of reasons.

First, it strongly suggests that the problem of sexual abuse on reserves is simply enormous. I will say more about this in Part III D.

Second, it demonstrates how very important it is to have skilled child abuse personnel working on reserve communities. DOCFS does not have them, and I will say more about this in Part III B.

Third, it points to the many obstacles that presently stand in the way of workers who try to follow through with the investigation and prosecution of sexual abuse cases from reserves. I will comment further about this serious problem in Part III A to E.

Fourth, it emphasizes the obvious necessity of having a system in place on reserves that allows a victim to make a

disclosure to a trained worker who does not come from the victim's reserve. To its credit DOCFS has now hired child abuse workers, at least partially to deal with this problem. I recommend that agencies responsible for reserves establish systems to ensure that victims have access to trained people not from their reserves. I recommend that the Director make certain that this is done, and that the systems are kept in place. I will say more about this in Part III B.

Finally, these examples touch on the problem of denial. In Part III D of this report I will discuss the problem of denial in more detail, and particular evidence that came forward at this inquest establishing that the problem of denial within the Indian community generally is a formidable problem, and certainly not confined to Sandy Bay. At this point, I will be content to state that denial and a desire to prevent problems that were forced to the surface from coming to the attention of the world outside Sandy Bay's border were major factors in this case. Denial within DOCFS is one of the main reasons why DOCFS (with the exception of Ella McKay and Bev Flett) continued to maintain that Marion Glover was the cause of their problems, in spite of overwhelming evidence to the contrary. Denial permeates every issue explored at this inquest.

I will leave the remainder of the discussion about sexual abuse, the reserve pattern, and denial for Part III D, and return now to the dispute between Marion Glover and DOCFS.

One of the complaints made by various DOCFS employees about Marion Glover is that she seemed to be preoccupied or obsessed with sexual abuse. I am convinced that one of the reasons for this is explained by the phenomenon noted by Marion Glover and Joyce Wasicuna, namely that sexual abuse disclosures tend to increase dramatically simply because competent, caring people not related to the perpetrators appeared on the scene, and were available to victims. To the untrained eye it would appear that the number of sexual abuse cases were increasing because the new child abuse workers were either obsessed with sexual abuse generally or were simply imagining sexual abuse where it did not exist. But there were other things at play here as well, including personality conflicts, and reserve politics.

Danta Kunzman, for instance, implied that most of these sexual abuse cases were in "Marion's head". In the case of Lester Desjarlais, Danta Kunzman and others within DOCFS seemed to dismiss the sexual abuse allegations almost out of hand. But in the case of Lester Desjarlais and other cases discussed at this inquest it is my opinion that the sexual abuse allegations were very real. I give my opinion in this report that the case of Donna Desjarlais was a classic case of sexual abuse. The concerns were legitimate and they were real. Marion Glover treated them that way. She was almost the only one within DOCFS that did.

It is clear that some of the DOCFS employees disliked Marion Glover intensely from the start. Delores Roulette

and Danta Kunzman are both examples of this. Delores Roulette said that at one point she could not stand to remain in a room alone with Marion Glover, she disliked Glover so much. Their dislike of Marion Glover was genuine, and it began before the case of Lester came to light. Marion Glover's personality was one of the factors.

But there were other reasons for this as well. In the case of Delores Roulette, she felt threatened by Marion Glover, and resented being passed over for the supervisor's position when Marion Glover was hired as supervisor. Although this will be commented on later in this report, I will note here that Delores Roulette was hired as a child care worker with no social work training or related experience. She had graduated from high school and had worked as a clerk-typist, and when she was hired by DOCFS she was designated as a child care worker. She only began her New Career's training three years after she was hired, namely in 1987. There were reasons for her to feel insecure. Although she was called a child care worker, by the standards of any non-aboriginal she would not have been entitled to assume that position. At most, she would have been an aid, or an assistant to a professional child care worker. So, insecurity was at least part of the reason for her resentment of Marion Glover.

Danta Kunzman clashed with Marion Glover over the handling of Lester's case and the case of Lester's sister Annette. But Danta Kunzman seemed to dislike Marion Glover

so intensely that her judgment was clouded where Marion Glover was concerned. In the case of Lester and Annette, Danta Kunzman was determined to have the children live with their mother, Joyce Desjarlais. Danta Kunzman had not even taken the trouble to look at Joyce Desjarlais's file. At the very least, a consideration of Joyce's history should have convinced Danta Kunzman to be very cautious. Instead, she deliberately attempted to upset Marion Glover's planning for Lester and Annette, even though Marion Glover was the supervisor for the files. She enlisted the support of Bill Richard, and she barged ahead with her plans in a reckless way. Ms. Kunzman simply dismissed serious allegations of sexual abuse, seemingly oblivious to the evidence. In these cases Danta Kunzman's judgment was not good. Her decisions in the case of Lester and Annette were poor. But her dislike of Marion Glover was genuine.

Marion Glover's employment was finally terminated by DOCFS. The main reason given was Marion Glover's fraudulent expense claims. It is clear that DOCFS legitimately claimed that Marion Glover had submitted fraudulent (duplicate) expense claims. However, it is equally clear that this was not the real reason for her firing - it was an excuse to be rid of her. Sometime after Mr. Daniels made his remark or threat to Marion Glover concerning her "fucking white ass", Wilfred Mousseau, then Director of Finance for Sandy Bay, and now an advisor to the Rousseau Indian Band, was

instructed to go over Marion Glover's file in order to find incriminating evidence in order to sack Glover.

Wilfred Mousseau admitted that many other DOCFS workers had submitted duplicate travel claims while he was employed at Sandy Bay. In part, the system was at fault, and Mr. Mousseau was responsible for introducing a better system to deal with travel expenses. That new system was not introduced until after Marion Glover's duplicate claims had been submitted. Exhibit 28, the material considered by Professor Freda Steel at the arbitration proceedings between DOCFS and Marion Glover, includes examples of duplicate claims filed by other employees. For example, Nos. 29 and 30 of Exhibit 28 are duplicate travel claims submitted by Ron Mousseau and Sandra Beaulieu. Sandra Beaulieu was not fired or even disciplined for this while she was with DOCFS. Ron Mousseau is not only still employed by DOCFS, but was promoted to the position of supervisor. (He is presently under suspension for other reasons.) DOCFS took no action in these cases.

Wilfred Mousseau and Marion Glover happened to run into each other in Winnipeg in February, 1992, that is after the arbitration proceedings had been concluded. Wilfred Mousseau apologized to Marion Glover. He said that he had lied at the arbitration hearings. He also told Marion Glover that Morris Merrick orchestrated the hatchet job (my term) and Ernie Daniels carried it out. This conversation was overheard by Teresa Contois, an acquaintance of Marion

Glover, and a credible witness. Wilfred Mousseau also admitted to trying to make amends to Marion Glover by taking Ms. Glover and her children out to dinner at Rae and Jerry's, an expensive restaurant in Winnipeg. Mr. Mousseau was crying when he apologized to Marion Glover and her children.

Ernie Daniels listed five reasons for Marion Glover's initial suspension in his letter to Glover dated July 11, 1988 (Number 16 of Exhibit 28). None of these reasons involved travel claims or had anything to do with finances. And yet, two weeks later Daniels wrote to Glover (Number 17 of Exhibit 28) and listed improper travel claims as the new reason for her suspension. They had found what they were hoping to find.

It is abundantly clear from the evidence that Wilfred Mousseau did not believe Marion Glover had been treated fairly by Morris Merrick and Ernie Daniels, and more to the point, that Morris Merrick and Ernie Daniels had not fired Marion Glover because of the duplicate travel claims, but instead they had gone looking for evidence to use against her after they had already decided to get rid of her.

I want to make it clear that I am not finding fault in any way with Professor Steel's decision (Exhibit 28), nor is an inquest of this type equipped to review such a thorough decision. That was a different proceeding dealing with different issues. However, I am satisfied by the evidence that at some point DOCFS decided to terminate Marion

Glover's employment. They then went looking for evidence to use against her, and they found the duplicate travel claims. It was not the other way around.

This is a brief description of the unfortunate relationship between Marion Glover and the DOCFS head office. I will not attempt to analyze it in greater detail. Much of the friction was caused because Marion Glover was insisting on tightening up procedure at Sandy Bay. Much of the friction was also caused by personality conflicts, such as the obvious conflict between Marion Glover and Delores Roulette, and the poisoned relationship between Marion Glover and Morris Merrick. Conflict was also caused by disorganization on Marion Glover's part. She was not a perfect supervisor by any means. In fact, her lack of expertise contributed to the problem. Much of the friction was caused by the fact, at least in the eyes of some people, that Marion Glover was not aboriginal. There were many contributing factors. In fact, neither DOCFS's childishly simple claim that Marion Glover was responsible for any confusion and mishandling of files on Sandy Bay, nor Marion Glover's assertion that the conflict came about solely because of her insistence on doing things right, were correct. The answer lies somewhere in between. But the DOCFS claim that Marion Glover was primarily to blame for the problems described at this inquest is a false claim.

Marion Glover the person remains an enigma. That she is a highly intelligent person can't be doubted. But beyond

that, the dichotomy between Marion Glover the person of integrity, and Marion Glover the manipulator; Marion Glover the capable professional, and Marion Glover the disorganized, inept amateur; Marion Glover the confident, articulate, advocate, and Marion Glover the insecure, self-doubter, will not be explored further in this report. Marion Glover remains to me a complex and mysterious person.

This is the extent to which I will examine the relationship between DOCFS and Marion Glover, and it is done to assist in understanding this case.

This is also the extent to which I will examine the Chief Medical Officer's first question.

Although this incomplete history does not "clear the air regarding the circumstances that led to this untimely death" it is offered as background information related to the first concern of the Chief Medical Examiner and I hope that it is helpful.

My recommendation is that foster parents employed by DOCFS be given proper training, and if a foster child is suicidal, or has other special needs, it is particularly important, and indeed vital, to ensure that the foster parents are thoroughly briefed about the child, and that the foster parents have a solid training with regard to these special needs.

Evidence given at this inquest convinces me that DOCFS has not given sufficient attention to this important subject. It is the norm in Canada for child caring

agencies, such as Child and Family Services of Western, and Central, to devote a great deal of time and attention to the education and training of foster parents. DOCFS falls far below that norm.

Recommendations similar to the ones I am making regarding training for foster parents have been made to DOCFS before. In 1984, DOCFS commissioned Pete Hudson and Brad McKenzie of the University of Manitoba School of Social Work to do an evaluation of DOCFS. Their report is Exhibit 74(1). Deficiencies were noted in the DOCFS foster care system and recommendations were made. At page 76 it is recommended:

> "That priority be attached to recruitment and training efforts that are designed to anticipate resource needs and provide supportive services to existing foster parents. Supportive services should involve the provision of more staff contact, more information on the difficulties experienced by children in substitute care, and the provision of information on resources available for assisting in placement adjustment."

In 1988 DOCFS commissioned Tim Maloney, former Executive Director of DOCFS, and other colleagues to conduct an organizational review of DOCFS. Their report, known as the "Yellowquill Report" was given to DOCFS in October, 1988. It is Exhibit 73(e). Yellowquill recommends at p.38:

> "That DOCFS develop and implement a strategy that will recruit, train, and support foster homes for special needs children, within DOTC communities. Such training and support may potentially

> draw from "professional parent" models used by urban agencies."

So, well intentioned recommendations have been made to DOCFS before with regard to training foster parents. Little attention has been paid to the recommendations. Isaac Beaulieu, DOCFS Chairman, testifies that DOCFS is now taking these things seriously and developing suitable programs. For reasons that will become more clear later in this report I am not confident that assurances from DOCFS can be relied upon at all. I am recommending that the Director become involved with DOCFS, and ensure that suitable foster parent education is developed, and that the Director monitor the situation to ensure that the programs are maintained.

A child care agency must ensure that foster homes are suitable and safe. If an agency cannot do that it has no right to exist.

I will now move on to examine the Chief Medical Examiner's second and third concern, and I will then attempt to offer clarification on the two issues put forth by Ombudsman Manitoba.

## B. AN EXPLANATION AS TO THE MISSING FILE ON LESTER DESJARLAIS

In fact there were two missing case files on Lester Desjarlais. It was explained to the inquest by DOCFS employees that when a file was opened, the working file, or community file, would stay at the DOCFS local office on the child's reserve. At the same time, a master file would be opened, and it would remain at the DOCFS head office in Brandon. If a child was placed away from his or her home reserve, the field or community file would sometimes accompany the child, but not necessarily. For instance, if a child from Sandy Bay was placed in Winnipeg, the child's file would normally be sent to Winnipeg for the use of the off reserve worker, who would work with the child. At the time of Lester's death, Danta Kunzman was the Winnipeg off reserve worker, and Liz Loane was the Brandon off reserve worker. When a file was to be closed, the field or community file was to be returned to head office in Brandon, usually by personal delivery. Both the field and master file would then be closed. In the case of Lester Desjarlais, both the field and the community file went missing, and they have not been found to date.

The missing files are very important to this inquest. The Chief Medical Examiner's Office originally decided not to request an inquest after concluding that Lester Desjarlais had committed suicide. But when it was discovered that Lester's files were gone, that office

decided that an inquest must be called, in part to "provide an explanation as to the missing file".

When the inquest commenced in October, 1991, fingers pointed at Marion Glover as the thief. She was suspected by the Brandon City Police (Sgt. Caroline Fisher concluded that Marion Glover was the prime suspect). She was also suspected by the RCMP (Cst. Irvin Bechtel believed Marion Glover had stolen the files "so as to remove all evidence against her"). And Marion Glover was accused by DOCFS as the thief (Morris Merrick blamed Marion Glover, for among other things, stealing and destroying Lester's files - perhaps, it was suggested in conjunction with Esther Seidl). There are reasons for the police officers's suspicions, and they will be outlined below, but there are also many holes in the theory that Marion Glover stole the files, and recent developments have cast even more doubt on the theory.

In the first place, after this inquest began, it was discovered that Lester's school files at Sandy Bay had also gone missing. Angela Eastman, the vice-principal for Sandy Bay Elementary School, testified that when the RCMP requested to look at Lester's school files, she discovered that both files were missing.

Two files are kept by the school on every child - the CUM file which contains all school records relating to the child, as well as a personal file that would contain teacher's notes and related material. Both files were gone.

They have not been located to date in spite of a top to bottom search.

People within the school had access to the files. Band councillors with child welfare or education responsibility had access to the school files. Others, including child welfare workers with a legitimate interest could ask a school secretary for a look at the file.

But the main point here is that Marion Glover had no access to the school files. Because of the public nature of this matter on Sandy Bay, any request by Marion Glover to look at the school files would certainly have been noted. The unsuccessful search for the school files did not offer up even a hint of Marion Glover's name.

The school files almost certainly went missing after Marion Glover had been fired by DOCFS. In short, the school files were stolen by someone other than Marion Glover.

In addition to the missing school files, evidence came forward at the inquest that other child welfare files, or parts of files, had been destroyed on the Sandy Bay Reserve on at least one other occasion. Dennis Roulette testified that after his employment as a DOCFS child care worker was terminated by DOCFS, he kept portions of child care files believing that they were his private property. Cecil Desjarlais, who was then the band councillor with the child welfare portfolio, found out that Mr. Roulette had these notes, and asked Mr. Roulette to destroy them. Mr. Roulette did so. The Sandy Bay Tribal Council actually authorized

this destruction of DOCFS property, and Isaac Beaulieu attempted to justify the improper decision. In fact it appears that Isaac Beaulieu may have been involved in the destruction of the files. He told the DOCFS representative who questioned him about these files at the time that not only was it proper for Sandy Bay to destroy DOCFS files, but Sandy Bay was considering breaking away from DOCFS and starting their own child care agency. This occurred when Isaac Beaulieu was Chairman of the DOCFS Board. He denied this at the inquest, but it is clear from the evidence that Mr. Beaulieu's recollection on this point is faulty.

Cecil Desjarlais was the chairman of the Sandy Bay School Board at the time that Lester's school file went missing. The Chairman of the School Board, said Angela Eastman, had access to the school files. Cecil Desjarlais, in the situation described by Dennis Roulette, had shown himself to be willing and able to facilitate the destruction of DOCFS files. Cecil Desjarlais also had access to child welfare files when Lester's child welfare file went missing.

So, someone other than Marion Glover was destroying files relating to Lester Desjarlais.

It has been mentioned that there were grounds upon which the police based their suspicions that Marion Glover was the file thief. Sgt. Caroline Fisher of the Brandon City Police testified that as part of her investigation of the missing files, she interviewed Marion Glover on July 14, 1988. The interview lasted approximately one and a half

hours. During the interview, Sgt. Fisher testified that Marion Glover told her that she had last seen the file on April 14, 1988, when she had left it at Sandy Bay for typing. Presumably this must have been the field file. (Sgt. Fisher does not distinguish in her evidence in places between the field file and the master file.) Sgt. Fisher testified that Marion Glover refused to give her a statement, and that although Marion Glover indicated at the time that she would take a polygraph, she later reneged on that commitment. These factors, combined with Sgt. Fisher's assessment that although Marion Glover seemed to be accusing many different people of stealing the files, she could offer no substantiation, convinced Sgt. Fisher that Marion Glover was the prime suspect in the theft of the child welfare files.

Marion Glover denied that she had ever met or spoken with Sgt. Fisher (then Cst. Fisher). She testified that her only contact with the Brandon City Police about the missing files was a brief discussion with Detective Brennan (a male).

If the interview with Sgt. Fisher was a very brief one it is conceivable that Marion Glover might simply have forgotten about it. But the interview was not brief. According to Sgt. Fisher it was one and one half hours in length, during which time Marion Glover discussed in detail problems of political interference on the Sandy Bay reserve, the political situation at the reserve, and the political

significance of the files. There is no reason to believe that Sgt. Fisher's testimony was not accurate and truthful. It is very difficult to understand how Marion Glover could forget such a lengthy and important interview.

The RCMP also had grounds for their suspicion of Marion Glover as the file thief. Cst. Bechtel, the RCMP constable who was investigating the case of the missing files for the RCMP learned from Cst. McInnis of RCMP Brandon subdivision, General Investigating Section, that on February 9, 1989, Cst. McInnis interviewed Marion Glover. Ms. Glover told Cst. McInnis emphatically that she knew nothing of the missing files, and that she wanted to take a polygraph test to clear the matter up. Cst. Bechtel made arrangements for the polygraph test, and instructed RCMP Cpl. Roach of Winnipeg subdivision GIS to contact Marion Glover with the place and time of the test. Cst. Bechtel was under the impression that Cpl. Roach had attended at Marion Glover's residence at 50 Brookshire Street in Winnipeg with this information. In fact, Cpl. Roach had telephoned Marion Glover with this information. In any event, Marion Glover told Cpl. Roach (now Sergeant Roach) that she was not going to take the polygraph test. This contributed to Cst. Bechtel's suspicion of Marion Glover as the file thief.

Marion Glover initially vehemently denied that she had ever been approached by anyone from the RCMP either in person or by telephone with information about the place and time for the taking of a polygraph test. However, after

Cpl. Roach gave his evidence to the inquest on April 15, 1992, Marion Glover announced that she was extremely embarrassed, and that she now remembered the conversation.

In addition, Sgt. Caroline Fisher and Cst. Bechtel both knew that Ron Mousseau, then a child care worker, and now a supervisor with DOCFS (presently under supervision) had stated that he had last seen Lester Desjarlais's file about one week after Lester's death at which time he gave it to Glover. It is not clear whether Mr. Mousseau was referring to the master file only, or the master and field file together. (I will comment in greater detail later about Ron Mousseau and his testimony at this inquest. Generally, I consider his testimony to be untrustworthy).

The RCMP and Brandon City Police suspicions of Marion Glover as the thief of the files were not without foundation.

However, although there are difficulties with Marion Glover's testimony, it is my opinion that it is extremely unlikely that Marion Glover stole these files. The police assumption that something contained in the files might incriminate or cast blame on Marion Glover is almost certainly wrong. From what I have seen of DOCFS files at this inquest, and from evidence related by witnesses, the files of Lester Desjarlais were probably grossly incomplete, and it is more likely that the files were stolen because of what they did not contain, than for what they did contain. Marion Glover really had no motive to steal the files. More

than any other person within DOCFS, Marion Glover was trying to bring attention to the case of Lester Desjarlais, and bring attention to Lester's disclosures of sexual abuse. The attitude of many other people within DOCFS, such as Danta Kunzman, Ron Mousseau and Morris Merrick, and the attitude of some residents of Sandy Bay, for example Cecil Desjarlais, was that Marion Glover was trying to make too much out of the sexual abuse allegations. As it turned out, Marion Glover was right, and they were wrong, but the point is that Marion Glover was one of the least likely people to want to hide what should have been on Lester's files.

I give my opinion in this report that Marion Glover failed to live up to her responsibilities as a supervisor responsible for Lester's file while he was in the care of Angus and Lillian Starr, but Marion Glover freely acknowledged that she did not make plans for Lester's counselling during that period of time, nor did she give Liz Loane instructions to do so. Marion Glover also freely acknowledged that she did not make sure that the Starrs had adequate information about Lester, and about suicidal children in general, before the placement was made. There would be no reason for Marion Glover to destroy the files to try to hide this information. I can see nothing else that could be on the files that would hurt Marion Glover's position. Further, I do not believe that Marion Glover had the master file on June 23, 1988, as alleged by DOCFS co-ordinator Elaine Scott. It is my opinion that Marion

Glover's evidence that she last saw the master file on April 15, 1988, when she was composing her letter to Jim Bakken, is more accurate.

The last credible report of the files' existence was Elaine Scott's information to the police that she had the master file with her at her meeting with John Chudzik on May 4, 1988. John Chudzik told the inquest that Ms. Scott had the file with her at the May 4, 1988 meeting and that she appeared nervous and reluctant to show the file to him. Mr. Chudzik testified that there was an aura within DOCFS of secrecy and nervousness surrounding Lester's case. The meeting had been arranged away from the DOCFS offices at Ms. Scott's request because of her anxiety and her fear. Elaine Scott testified that she had only some papers from the file with her at the May 4, 1988 meeting, that she was not nervous, or reluctant to show Mr. Chudzik the file, and that the meeting was at the Provincial Building and not the DOCFS offices only because the DOCFS office did not have enough room.

I believe Mr. Chudzik's testimony concerning this meeting, and I do not believe the testimony of Ms. Scott. There was anxiety within DOCFS about Lester's file. The senior staff was nervous.

There is no credible evidence that either file was seen by anyone after May 4, 1988. Therefore, the files disappeared sometime between May 4, 1988 and July 6, 1988, at which time Marion Glover discovered that the master file

had gone missing when she was attempting to prepare herself for her meeting with Hedie Epp, which had been arranged on July 5, 1988.

It is not clear who stole the files. This report is not able to offer an explanation as to the missing case files on Lester Desjarlais as requested by the Office of the Chief Medical Examiner. I have suspicions only, and it would not be fair to name the suspects. My prime suspect is not Marion Glover.

C. "CURRENT POLICIES AND SECURITY MEASURES PERTAINING TO THE CARE OF THE FILES OF THE DAKOTA OJIBWAY CHILD AND FAMILY SERVICES AGENCY"

In October 1988, Morris Merrick explained that when a file was opened on a child, two files would actually be created. One would be a master file. It was to remain at the head office of DOCFS at all times. The other file would be the working file, or field file. It would be kept at the local DOCFS office on the reserve where the child resided. The field files were to be kept under lock and key. The worker had keys to the cabinets. The master files in Brandon were to be kept in a locked cabinet, but at the time Lester's files went missing, Morris Merrick was unable to recall whether or not there was any kind of security system at all in place to keep track of the files during the day. Mr. Merrick remembers that a system regarding the signing in and out of files was being considered, but he does not remember whether a system had been put in place in Brandon at the time when Lester's files disappeared. He does remember that whether or not a system was in place, many people, including workers, supervisors, clerks, and support staff had access to the files, and workers could take the files home with them if they wished.

Mr. Merrick explained that since then DOCFS has placed controls on the files. Workers can no longer take files home with them. In fact, anyone wanting a file must ask a clerk for the file, and the clerk will fetch it for them.

That is not exactly the way Olga Hart and Margaret Ann Raine described the situation. Both women worked as clerks in the DOCFS head office in Brandon at the time Lester's files went missing. Margaret Ann Raine left DOCFS on May 24, 1991. Olga Hart is still there. They said that no system was in place when Lester's file went missing. Workers, or anyone with an interest in the file could help themselves, if they knew the file numbers, or ask the clerk to fetch the file.

Ms. Raine said that as a result of the missing files, a system was put in place. Cardboard sheets were made. When people took files, they were to sign the manilla sheet attached to the cardboard, and list the date and the file number. The cardboard was to be inserted in the cabinet in place of the file. According to Ms. Raine, that system had fallen into disuse when she left the agency in May, 1991, and nothing had taken its place.

Olga Hart also testified that a system was put in place after Lester's file went missing, and that the system is no longer in effect. People who want a file either personally retrieve it or ask Ms. Hart or another clerk to get it for them. There is no requirement to sign for a file. In fact, Ms. Hart volunteered the information that if she saw files on desks at the end of the day, she would gather them up and lock them in the cabinet. I would guess that there would be other files that would not be observed by Ms. Hart - in brief cases, desk drawers and the like.

Isaac Beaulieu testified that this, like other problems described at this inquest, may have been a problem in 1988, but DOCFS has now taken steps to rectify the situation. Bev Flett and Ella McKay put the lie to that one. Bev Flett is an assistant executive director of DOCFS. Ella McKay is a senior supervisor. They say that the problems have not been solved at all. There is no file security. Morris Merrick also acknowledged in his June testimony that this problem still exists. According to Mr. Merrick, DOCFS spent $23,000.00 on file security to no avail.

The answer to the Chief Medical Examiner's concern about current policies and security measures pertaining to the case files at the Dakota Ojibway Child and Family Service Agency, at least dealing with files at DOCFS head office in Brandon, is that if policies or measures do exist on paper, they are not actually in effect. No security measures exist.

As far as the working files at Sandy Bay are concerned, the situation did not seem to be much better. Files could be removed without signing for them. They could be taken from the office, and there appeared to be no effective security system in place.

Sgt. Caroline Fisher of Brandon City Police testified that when she investigated the matter of the missing file on Lester she discovered that DOCFS workers were taking files home with them. It was Sgt. Fisher's opinion that it was

common knowledge that files would be taken routinely, with no system in place to protect confidentiality.

I will be recommending that at the reserve level, and at the head office of DOCFS, a security system satisfactory to the Director be implemented to protect files, and that the Director monitor the situation to ensure that the security system is maintained.

There was also evidence that came forward at this inquest that some of the files represented by DOCFS to be their actual working files had in fact been "manufactured" by DOCFS. For example, the file tendered by DOCFS and said to be the file of Donna Desjarlais, did not contain much of the information that should have been on the file. Marion Glover testified that she was very familiar with Donna's file, and Exhibit 27 was not that file. In Marion Glover's opinion, Exhibit 27 has been manufactured by DOCFS for use at the arbitration proceedings between DOCFS and Marion Glover.

It transpired that Exhibit 27 was not the only DOCFS file on Donna Desjarlais. DOCFS had opened a separate abuse file on Donna Desjarlais in January, 1990, and for reasons that were not satisfactorily explained to the inquest, the file was not made available to the inquest after I made an order for production of Donna's files in fall. Although that file was labelled "Donald and Donalda 5082" it is clearly an abuse file on Donna Desjarlais. DOCFS was ordered to produce their files pertaining to Donna in

October 1991 and did not do so. Because I have ordered an investigation concerning that matter, with possible criminal charges to follow, I will not offer views on criminality, and I will not go into detail about this file. I will provide a skeleton outline only and leave the resolution of that issue to a different forum.

Bev Flett testified that she became aware that another DOCFS file on Donna Desjarlais was in existence on January 9, 1992. She discussed this with others within DOCFS, including Morris Merrick, and later was told by Mr. Merrick that he would look after the matter. In fact Morris Merrick was concerned enough about the discovery of this new file and Ron Mousseau's failure to mention the existence of the file to anyone within DOCFS that he discussed disciplinary action against Mousseau with Bev Flett and Linda Pompana. Mr. Merrick authorized a memo to Irene Garneau, the DOCFS abuse worker responsible for Sandy Bay, requesting that Ms. Garneau do a follow up investigation regarding Donna. Mr. Merrick later countermanded this memo and told Ms. Garneau that she was not to do follow up investigation. Mr. Merrick also discussed the significance of this new file with Bev Flett and other senior DOCFS employees. Therefore, Mr. Merrick was very much aware, from January 9, 1992 until June 22, 1992, of the existence of the new file, and the importance of the file to the inquest. It seems inconceivable that he did not think of the inquest in relation to the discovery of the new file. The inquest was

a major event within DOCFS. Mr. Merrick knew as early as January 9, 1992 that the new file had been discovered. He did nothing to bring the existence of the file to the attention of anyone connected with the inquest.

I have turned over the investigation of this matter to Lawrence McInnes in his capacity as the representative of the Crown. I will therefore not discuss DOCFS' failure to turn this file over to the inquest other than to say that this is an extremely troubling incident. It must be pursued.

Bev Flett testified that she finally decided to tell John Chudzik, Manitoba's Child Abuse Coordinator, about the new file (Exhibit 107) after reading newspaper accounts of Mr. Bakken's testimony at this inquest following Mr. Bakken's first inquest appearance on May 19, 1992. Ms. Flett formed the opinion after reading the newspaper articles that Mr. Bakken could not have known about the new file. When she told John Chudzik about this file on June 2, 1992 it was clear to her that indeed the Director's office did not have copies of the file material or any prior knowledge of the file's existence. Bev Flett's evidence on this point corroborates evidence from Mr. Bakken's counsel that the Director's office first became aware of this new file on June 2, 1992.

It is also clear that the discovery of this new file was of significance to the Director's office. The new Director, Ron Fenwick, personally told DOCFS by telephone to

"get it (the new file) in here quick or DOCFS will be in big trouble". Bev Flett told John Chudzik the history of the new file. The Director's office would have to have understood that the file had not been turned over to the inquest last fall. At the very least, a discussion with Lawrence McInnes or one of Mr. McInnes's colleagues would have very quickly cleared up any ambiguity on that point. And yet, the Director's office did not tell Mr. McInnes or anyone associated with the inquest about this file when they found out about it on June 2, 1992; when they received it on June 5, 1992; at any time between June 5, 1992 and June 16, 1992 when Mr. Bakken testified at the inquest for the second and final time; on June 16, 1992 when Mr. Bakken was asked questions about Donna; or between June 16, 1992 and June 22, 1992, at which time Bev Flett told the inquest about the file.

If Bev Flett had not come forward, the inquest would not have known about the new file. The Director did not know that Bev Flett, or any senior people within DOCFS were intending to give candid information to the inquest about the inner workings of DOCFS. I am lead to the extremely disturbing conclusion that Mr. Bakken, Mr. Chudzik and their senior colleagues made a calculated decision to withhold important information from this inquest.

I was asked to extend the inquest to deal with the issue of the new files and the actions of DOCFS and the Director's office. I declined to do so for several reasons,

including the need to bring the inquest to a conclusion, and I turned the matter over to the Crown. Because the actions of Mr. Bakken and his staff pertaining to the new file are under investigation I will shorten this discussion. I will comment further about the policies of the Director in a later chapter, and I will offer critical comments about what I see as weakness, and a lack of commitment to the protection of aboriginal children, within the directorate. But at this point I will leave the issue of the disturbing and disappointing reaction by the Director to the chance discovery of the new file. This is not a matter that should be ignored or excused.

There was also other troubling evidence offered about DOCFS files at this inquest. In the case of Exhibit No. 26, a file that was represented by DOCFS to be the file of Joyce Desjarlais, present DOCFS employees, including Ron Mousseau and Bill Richard, testified that the Joyce Desjarlais file they were familiar with was at least twice as thick as Exhibit No. 26. The "social history" on Exhibit No. 26 was undated and there was no indication on the document as to who prepared it. None of the witnesses familiar with Joyce Desjarlais's file knew anything about this document. It looked suspiciously like a document that had been prepared for some reason by someone within DOCFS after the death of Joyce Desjarlais.

There were many other serious discrepancies in these files, and in particular with the files of Donna Desjarlais,

Joyce Desjarlais and Allison Desjarlais (Exhibit No. 34). These were not simply examples of the poor file recording and general sloppiness which was characteristic of the DOCFS files presented to this inquest. They were examples of deliberate attempts by someone within DOCFS to mislead.

This was one of the many issues that emerged during the course of this inquest that I decided not to pursue in detail. It was apparent to me that if I allowed the inquest to move into any of these areas that were not directly related to the issues I was required to deal with, the inquest would become impossibly long. But these files that had been deliberately tampered with were of great concern to me. I am going to recommend that the Director conduct a comprehensive file review at DOCFS. I stress the word comprehensive. I am going to recommend that the Director work on all aspects of DOCFS file recording and file keeping. After the situation is rectified I am going to recommend strongly that the Director monitor the situation to ensure that improvements made in this process are not lost.

Later in this report I will discuss the new Office of the Child Advocate. I will also discuss what I view as a virtual absence of the Director from matters having to do with aboriginal child welfare agencies. Because of the extremely disturbing testimony concerning the new DOCFS file (Exhibit 107) and the unexplained failure of Mr. Bakken or anyone from his department to bring the existence of the

file to the attention of the inquest, I must recommend that the Child Advocate actively monitor the Director's involvement in this case, and ensure that the Director is properly carrying out his duties .

I will not pursue the problem of altered files further in this report. It is a deeply vexing aspect of this case.

Although I was asked to deal with the question of file security only, I will add a brief comment about DOCFS file keeping in general. Every one of the files examined at this inquest was notable for the absence of documents that should have been on file, the lack of continuity in the file, and generally for what appeared to be a very poor system of recording and file keeping. I will not go into detail on this point. However, I have seen enough to convince me that a serious problem exists. I will be recommending that the Director commence a general review of DOCFS files with the goal of rectifying this problem, and that after a system satisfactory to the Director is established, the Director monitor the situation to ensure that the system is maintained. An agency cannot do its job properly with the current sloppy system.

When working on the file system of DOCFS, the Director should not let himself be diverted from his task by vague references to aboriginal tradition being oral and not written, and other weak arguments. These are excuses only. Good file keeping is just as necessary for an aboriginal agency as for a non-aboriginal agency. Aboriginal workers

are every bit as able to keep good notes and running records as other workers.

This is not to say that there are not legitimate cultural differences at play here. Isaac Beaulieu described how some aboriginal people may have difficulty taking notes while a fellow aboriginal is talking to them. It may be construed as a sign of rudeness by the person speaking. The person speaking may feel that what he or she is saying is not considered important, if the other person is taking notes, rather than actively listening. Non-aboriginal social workers would not be burdened with this problem.

Mr. Beaulieu did acknowledge, though, that it was incumbent on Indian agencies to overcome these problems so that files can be properly kept. He gave the example of tape recorders being used by aboriginal people in instances where notepads might be used by non-aboriginal people. Obviously, these are problems that can be overcome, and the onus is clearly on aboriginal agencies to do so.

In response to Mr. Beaulieu's suggestion that the Indian oral tradition is an impediment to proper note taking, Wayne Govereau, formerly a senior native liaison worker with the directorate, pointed out that although the original tradition was oral, modern aboriginal society has by now evolved into a written society. In fact, even the most traditional person of today's aboriginal community is not the Indian of the birch bark canoe and the bow and arrow, anymore than today's non-aboriginal is the man of the

quill pen and the flintlock rifle. Child welfare "agencies" themselves would be foreign to the Indian community of the past. It is incumbent on today's aboriginal community to adapt and learn if it is that community's goal to operate entities such as child welfare agencies. A fundamental requirement is that proper files be kept.

My findings that file recording and file keeping in general by DOCFS is poor is not news. In fact, similar recommendations have been made to DOCFS before. The Hudson Report (Ex. 73(b) ) notes that file keeping at DOCFS is inadequate (p.X). At p. 49 Dr. Hudson states:

> "Files were assessed for the adequacy of recording. Recording is not necessarily a good indicator of service, however, file information does enable new staff or others who must provide immediate or emergency service to have some general understanding of the problem, service plan and progress. File recording was judged as inadequate if there was no file recording within the past six months and service activity had occurred. In 8 of 12 Family Service cases recording was judged to be inadequate and in 5 cases there had been no file recording in more than a year."

Dr. Hudson recommended (at p.50):

> "That all staff and committees give increased attention to the need for file recording and follow-up service to families receiving service from the agencies".

That was in 1984. In March, 1989, the situation had not improved. The Review Notes on Child Protection/Abuse cases at Sandy Bay Reserve, undertaken by The Department of

Family Services (Appendix v. at Ex. 53(b)), which is referred to generally as the Govereau/Chudzik study, found at p. 31:

> "Based even on this brief and cursory review of agency files, the reviewers found that the recordings were generally inadequate and lacking in detail. The files lacked continuity, case reviews, planning objectives and clear statements of outcomes. Often, the initial steps taken in a particular case were recorded and then little follow-up information as to what action was taken or what happened would be recorded. Supporting documentation, such as medical and police reports, were not consistently on file.
>
> The poor quality of the file recording raised a number of questions around the value placed by the agency and staff in detailing case matters, and having the documentation monitored or supervised and used as a basis for measuring case progress and/or accountability, and the breakdown in communications and the supervisory process. There appeared to be a reluctance to record details, not only by the regional workers but also by the supervisory or senior staff."

DOCFS did not act on Dr. Hudson's recommendation in 1984. The situation worsened. The Director did nothing to force change in response to the observations of Mr. Chudzik and Mr. Govereau in 1989. The result is the dismal state of the DOCFS files examined at this inquest. It is now time for DOCFS to act to correct this serious problem. The Director must actively assist DOCFS, and make sure that the file situation is corrected.

A child care agency that cannot keep proper files must not be allowed to continue operating.

## PART II

A. "WHAT ACTION WAS TAKEN BY THE DAKOTA OJIBWAY CHILD AND FAMILY SERVICES TO INVESTIGATE THESE ALLEGATIONS OF SEXUAL ABUSE AND WHETHER ANY INVESTIGATIONS WERE CONDUCTED IN ACCORDANCE WITH THE MANITOBA GUIDELINES ON IDENTIFYING AND REPORTING CHILD ABUSE WHICH WERE IN EFFECT AT THE TIME?"

Lester Desjarlais complained to more than one person that he had been sexually abused. Marion Glover took these complaints very seriously. Other people within DOCFS took a much more relaxed attitude. For instance, Danta Kunzman, DOCFS's off reserve worker in Winnipeg was very skeptical about the allegations of sexual abuse. That seemed to typify the attitudes of other people within DOCFS as well, including Morris Merrick. There seemed to be a belief that Marion Glover was either imagining things or else that she was overly concerned with sexual abuse.

It should be noted that Lester did not make his disclosure about sexual abuse by Joe Desjarlais to Marion Glover in one complete statement. Early on in their relationship Lester told Marion Glover that Joe Desjarlais had tied him to a tree, but he got away. Sometime after that, Lester told Glover that Joe tied him to a tree, but his older brothers came along and beat Joe up and freed him. It was not until sometime in January, 1988, that Lester admitted to Glover that Joe had not only tied him to a tree, but had anally raped him as well. It was at this time that Glover attended with Lester at the Amaranth RCMP station and Lester reported this to Corporal (now Sergeant) Tom Bush. Glover had previously told the RCMP about Lester's possible

sexual abuse by Joe Desjarlais, but she had been advised by the RCMP that the details were still too vague for any action to be taken. The inquest was informed by Lawrence McInnes that the RCMP acknowledge that Sergeant Bush received this information but are unable to provide any written verification of it.

Lester did not complain only to Marion Glover about being sexually abused. Angela Eastman, the vice-principal of Sandy Bay School, testified that Lester confided in her, and revealed that Joseph Desjarlais had tied him up and raped him. This was not a minor matter to Lester. It was of extreme importance. Lester was very ashamed of this incident, and I am convinced that it weighed very heavily on his mind. Lester related this incident to Angus Starr shortly before his death, and it is clear that he was very troubled by it.

The other sexual abuse disclosure made by Lester that bears close examination is the matter involving James Boyd Waddell. Though not as grisly in its details as the rape allegation concerning Joseph Desjarlais, it is none the less frightening in the attitude revealed to the sexual abuse of children at Sandy Bay by that community.

Marion Glover testified that Lester told her that he did not like Mr. Waddell, and that is one of the reasons why Lester did not want to go back to the school. Ms. Glover said that Lester told her that Mr. Waddell had pornographic magazines that he kept in the top drawer of his desk, and

he would sometimes keep Lester after school, and want to show Lester pictures from these magazines. Mr. Waddell would stroke Lester's legs in the thigh area, and he offered to take Lester to his home (a house trailer) that was located off the reserve. Lester referred to Mr. Waddell as a "fag", and he was very uncomfortable with the idea of having anything to do with Mr. Waddell.

Now, it turned out that Mr. W..dell was in fact a convicted child molester, and that he was later convicted of sexually assaulting boys while at Sandy Bay. So the concern Marion Glover had about James Waddell was not frivolous or exaggerated. It was a legitimate concern about a real menace. But Marion Glover appeared to be alone in her concern.

James Boyd Waddell had been teaching at Sandy Bay when it was discovered by Ilene Beaulieu, who was employed by the school, that Mr. Waddell's teaching certificate had been revoked. Ms. Beaulieu consulted Marion Glover, and asked Ms. Glover to look into the matter. Because of what Marion Glover described as a "gut feeling" about Mr. Waddell, Marion Glover obtained his resume from Ilene Beauleau, and discovered that Mr. Waddell's last job had been at a school in British Columbia. Marion Glover checked the B.C. child abuse records, and lo and behold, it was discovered that Mr. Waddell had his teaching certificate revoked because he had been convicted of sexual offences against young children. One of those children was apparently a special needs child

that Mr. Waddell had fostered, and the other two children were step sons from a marriage. Marion Glover researched the matter further, and testified that she placed all of these investigations in Lester's file (which has gone missing).

The startling thing is this: When Marion Glover took this information to the Sandy Bay Education Board, and demanded that they fire him, instead of universal outrage and concern for the children, Marion Glover was told that Mr. Waddell was the best special education teacher the reserve had ever had, and that they didn't want to lose him. It was only because Marion Glover pursued the matter with the RCMP that the Board reluctantly terminated Mr. Waddell's employment as a teacher. Even then, Mr. Waddell wasn't really fired, his employment was simply changed to that of a consultant. Mr. Waddell later disappeared, and when he turned up he was charged and convicted of sexual crimes against boys that he had committed while he was employed as a teacher on Sandy Bay.

This evidence to my mind is astonishing. If it was discovered that a school teacher in Brandon had been convicted of sexually molesting children, and had lied about having a certificate in order to obtain employment as a teacher in Brandon, there would be a local scandal. Action would be taken immediately. There would be outrage. This did not happen at Sandy Bay. In fact, if Marion Glover had not persisted, Mr. Waddell might be there still.

Marion Glover made all of this information about James Boyd Waddell known to DOCFS (more accurately, she refused to shut up about it) but even after this, witnesses from DOCFS seemed to downplay or minimize the importance of this, and accuse Marion Glover of being preoccupied with sexual abuse. I will deal with the subject of denial further on in this report.

When Marion Glover began to check up on James Waddell she had cooperation from British Columbia. Their registry system, and the staff in charge gave Ms. Glover the information that Waddell was listed in the abuse registry, that he had been convicted of sexually assaulting his foster child, and that he had had his teaching certificate revoked as a result of this conviction.

When Marion Glover attempted to find the information she required about Waddell in Manitoba, she met with an entirely different response. She testified that it was "like pulling teeth" to get any information, and the entire registry system appeared archaic in comparison with the system in place in British Columbia.

I note that these issues are receiving attention from the Manitoba Department of Family Services. In the Government Response to The Independent Review of Reporting Procedures in Children's Residential Facilities, (Exhibit 82) it is stated at page 4, under "Current Status":

> "There is a strong belief in the protection/abuse system that third party

> assailants who are convicted (i.e. pedophiles) should automatically be listed on the registry. These are the most serious of offenders and most likely to re-offend.
>
> There is no other tracking vehicle outside of Canadian Police Information Centre for many of these offenders."

The "Action Plan" of Family Services is as follows:

> "Refer this recommendation to the legislative review scheduled for 1993. Consult with the police, Justice, and the Provincial Advisory Committee on Child Abuse in regards to the broader implications of such a charge."

That James Waddell could obtain a teaching position on a Manitoba reserve, and that Marion Glover had to make extraordinary efforts to overcome Manitoba bureaucracy in order to expose the truth is scandalous.

I repeat the recommendations made in the Suche Report, (Exhibit 60), namely:

> "The Child and Family Services Act be amended to include a specific definition of third party assault and the Act clearly state that third party assault is subject to the mandatory reporting provisions."
>
> and
>
> "Section 19(4) of The Child and Family Services Act be amended to include persons convicted of criminal offences against children."

I also recommend that the government not wait until 1993 to deal with this deficiency, and address the problem on an urgent basis.

I recommend that the government promptly study the child abuse registry system in its entirety to improve efficiency and effectiveness, with a special emphasis on the tracking system.

A similar example of the unusual attitude towards sexual offenders that seemed to prevail at Sandy Bay and within DOCFS at Sandy Bay, involved the case of Joe Desjarlais, that is Joseph Adelaide Desjarlais. Joe Desjarlais was a convicted sex offender. The evidence was that he had been convicted of a very serious sexual assault against an eleven year old girl, and that he had been sentenced to Stony Mountain for that assault. A horrifying detail that sheds light on the depth of his depravity involves one of his sexual assault charges involving a young boy. The victim's anus had to be surgically stitched together after the assault. Joe Desjarlais was the suspect in numerous sexual assaults on the reserve, and it was generally known that he was a danger to children, and responsible parents kept their children away from him, out of fear that he would molest them.

There were many examples given at the inquest of the danger that this man posed to the community. Deputy Chief Warren Fontaine of the DOTC Police described an incident where he was attacked by a growling Joe Desjarlais, and he was lucky to escape without being injured. Other police witnesses described similar incidents, including Constable Miller's account of Joe Desjarlais coming at him with a tree

limb. In general, very convincing evidence was offered that Joe Desjarlais was a dangerous, unpredictable person, and especially dangerous to children. In fact, halfway through the inquest it was announced that Joe Desjarlais had again been charged with sexual assault, this time involving a woman who had been cleaning his house. Joe's brother, Cecil Desjarlais, would protect Joe, even to the point of interfering with police investigations and with DOCFS apprehensions.

But, in spite of the obvious danger Joe Desjarlais posed to children on the reserve, he became a member of the Sandy Bay Youth Justice Committee. The evidence is that he sat on that committee for some time with no objection from the other members, or from the community at large, until the DOTC Police objected to his presence there. That pressure resulted in Joe Desjarlais leaving the committee.

If that was not bizarre enough, Joe Desjarlais at one point seriously suggested that he should be given money to start a home for troubled youth. Although the evidence of this is vague, it appeared that he was actually taken seriously by some people on the reserve, and again it was only when the DOTC Police strongly objected to the inappropriateness of this suggestion that the idea was abandoned.

As in the case of James Waddell, the response of the Sandy Bay community to this must be compared to the probable response of other communities. It is inconceivable that a

convicted child molester with a history like that of Joe Desjarlais would be able to sit on a Youth Justice Committee in a healthy community. But Joe Desjarlais was protected by his family, and the rest of the community did not voice the outrage that would be expected from them.

Two final examples of this strange attitude. I noted that Isaac Beaulieu, Chairman of DOCFS, took pains to point out a number of times during his testimony that the sexual assault charges against Joe Desjarlais that had been dismissed because the children later recanted were "allegations" only. This included the case of the boy who told the police that Joe Desjarlais had anally raped him, and had to have his anus stitched up. It is true that those charges were allegations only, and one expects that certain people, such as counsel for the accused, will point this out carefully. (It is also true, as I mentioned earlier, how almost none of the sexual abuse disclosures made by children from reserves make it past the "allegation" stage.) But it is extremely odd for this type of admonishment to come from the chairman of a child care agency that has the protection of children as its paramount goal. Isaac Beaulieu gave this defence of Joe Desjarlais almost immediately after telling the inquest that it was his information that Joe Desjarlais had been charged on twenty-one occasions with crimes involving violence and/or sexual assault, and had been convicted ten times. (Isaac Beaulieu is referred to in this report as chairman of DOCFS. In fact, in the spring of 1992

he became vice-chairman. Because he was chairman for many years, including the time periods most relevant to this report, I will refer to him throughout this report as chairman.)

Similarly, Morris Merrick defended Joe Desjarlais in a press interview after this inquest recessed last fall, and claimed that Joe Desjarlais "was not really a bad guy once you got to know him".

The attitude of the senior child care agency officials to a person who is obviously a dangerous sexual offender is utterly astounding.

In conclusion, only Marion Glover took Lester's allegations of sexual abuse seriously. She brought the allegations to the attention of the police, as was required by the guidelines. She also brought the allegations to the attention of BMHC.

It was when she tried to deal with the allegations within DOCFS, and within the Sandy Bay community, that she ran into difficulties. Generally, DOCFS refused to take the allegations seriously, preferring to believe that Marion Glover was imagining these things, or at the least was overly concerned with sexual abuse. The general response of the Sandy Bay community was silence and denial.

Marion Glover complied with the guidelines. The rest of the DOCFS personnel who knew about the allegations did not.

The sexual abuse of children is a horror of our time. Lester was only one of a depressingly large number of children who are used like meat by their elders for sexual purposes and then cast aside with their childhoods in shreds. I will concentrate later in this report on evidence that the problem of sexual abuse on Indian Reserves is a problem of "epidemic proportions". I will also discuss the cases of other children, most notably the case of Donna, in which children are victimized first by abusers and then by the very institutions that are expected to protect them. I will then make recommendations for change, including recommendations made five years ago by Manitoba's foremost experts in the child abuse field - recommendations that were dismissed summarily by an unconcerned Indian leadership and ignored by timid governments.

B. "WAS THE RECOMMENDATION THAT LESTER RECEIVE THERAPY FOR SEXUAL ABUSE ACTED UPON?"

The answer to this question is "no". Between the time of Lester's third and final discharge from BMHC on February 11, 1988 to the time of his death on March 6, 1988 no plans were made for Lester to receive sexual abuse therapy or treatment of any kind. Marion Glover was the supervisor and hence responsible for Lester. There is no evidence that Marion Glover gave instructions of any kind to Liz Loane, the off reserve worker, to plan for sexual abuse therapy.

But it must be noted that Lester Desjarlais was not in a position to benefit from counselling then or at any time while Marion Glover had his file. In the case of a child like Lester Desjarlais, it would have been a major accomplishment simply to stabilize him for a while. Only after the child had been stabilized would an agency normally begin thinking of treatment. Liz McLeod of BMHC testified that with a child like Lester, where there were so many terribly serious problems, the immediate concern would be to try to prevent the child from hurting himself, and then the second priority would be to try to stabilize him. DOCFS was nowhere near that point with Lester Desjarlais. He had been in at least eight placements in the previous year, and all of the evidence indicates that 1987 was not an unusual year for Lester. Marion Glover was hoping that Lester would form an attachment at the Starr home and decide to stay. I do not find it unusual that sexual therapy was not immediately arranged for Lester after his placement at the Starr home.

I also do not find it unusual that sexual therapy had not been arranged before that time. Again, the immediate concern was to try to keep Lester in one place for a while. At no time during 1987 was Lester stable enough to think seriously about sexual abuse treatment. The disclosure in its complete form was not made to Marion Glover, and it must also be remembered that a number of people within DOCFS did not take the allegations of sexual abuse seriously in any event. They were regarded as something in Marion Glover's head. I do not fault Marion Glover for not making arrangements for sexual abuse therapy under these circumstances.

She did try, with the placement of Lester at the home of Arthur and Virginia Roulette, to provide a "culturally therapeutic home" (my term) for Lester. She also made herself available to discuss issues with Lester when he wanted to talk. Although she was heavily criticized for taking Lester to her home on some weekends, Marion Glover was obviously trying to do her best for Lester, and under the circumstances I do not believe that she could have done much more. She was the one who brought the sexual abuse allegations to the attention of BMHC. Their formal recommendation was made as a result of this information. A few weeks after the recommendation was made by BMHC, Lester took his life. I do not fault Marion Glover or Liz Loane for not implementing a plan for sexual abuse therapy.

## PART III - RELATED PROBLEMS THAT SURFACED AT THIS INQUEST

### INTRODUCTION

This ends the portion of my report that responds to the concerns and questions raised by the Office of the Chief Medical Examiner, and Ombudsman Manitoba. It is my hope that the responses have been helpful. However, because of the evidence that came forward at this inquest, I am not able to conclude my report at this point. As the witnesses came forward and testified at this inquest, I became convinced that there are serious problems within DOCFS that are not confined to the case of Lester Desjarlais, and that these problems are seriously interfering with the agency's ability to protect the children within their jurisdiction. In addition I became convinced that there were major contributing problems at Sandy Bay, and in Winnipeg. Finally, the evidence convinced me that the Sandy Bay situation, described in detail at this inquest, was typical in most ways of the situation existing on other reserves in this province. Consequently, the remainder of this report will be devoted to a discussion of these problems. I will begin in part with an examination of a very troubled agency - DOCFS.

Before setting out what I perceive to be the main problems within DOCFS, I will say that I do recognize that child welfare agencies in general carry a very heavy load. Isaac Beaulieu and Bruce Fraser touched on this. Agencies have mandates that are impossible to achieve - to protect

all of the children within the area covered by their mandate, and ensure that all of the children that they have to take into their care are able to achieve their potential. In theory this is easy. If parents are having difficulty raising their children, the agencies can offer help and assistance, with the goal of keeping the family together. If this proves impossible, because the parents or parent are unable or unwilling to accept the help, the agency removes the child, and places the child in a suitable home. Plans are then made for the child. If the agency can work with the family, a temporary order is obtained (or a voluntary placement agreement). The agency then works with the child and family, with the goal of reuniting the family. If this is not possible, or if the goal is not achieved, plans for the permanent placement of the child are made, and an application is made to court for a permanent order.

Aboriginal agencies tend to apprehend less often than non-aboriginal agencies, although the emphasis in child welfare generally in the last few years is to apprehend less and concentrate more on preventive work. Jim Bakken spoke of this at the inquest. In this case, DOCFS philosophy has been incorporated into the philosophy of non-aboriginal agencies.

The theory is impeccable, and in many cases this is more or less how things work. But real life can ruin the theory in many ways. In some cases, the child has been very badly hurt by the time the agency intervenes. A child who

has spent even a small portion of his life in an atmosphere of abuse, neglect, and chaos, will never be a "normal" child. An agency, no matter how well run, will have great difficulties in these cases.

Lester Desjarlais was such a child. His mother was a chronic alcoholic. Even before DOCFS took over the file, Children's Aid (Central) was involved with the family. In retrospect, it is clear that Lester should have been removed from his mother's home at a very early age - probably at birth. Neither Children's Aid (Central) nor DOCFS took this step.

But this is hindsight. Neither agency can be labelled negligent for this. It is easy to fault child care agencies, especially in hindsight. They have an impossibly large job, and they can only do their best in the case of each child to fulfill their mandate.

It is expected, though, that child caring agencies will employ qualified child care workers, and that the organization will operate in a competent, professional manner. In the case of Lester Desjarlais, it is my opinion that these expectations were not met. It is my opinion from the evidence that came forward at this inquest that there are serious problems that interfere with the ability of DOCFS to carry out its mandate.

The first problem relates to confusion within the structure of DOCFS, and the second problem relates to the qualifications and training of the DOCFS child care

personnel. The other problems are found in the environment in which DOCFS operates. I believe that it is my responsibility to comment on these problems, and I will do so in this report.

A. CONFUSION WITHIN THE STRUCTURE OF DOCFS

The structure of DOCFS was described at the inquest by a number of witnesses, including Esther Seidl, former Executive Director of DOCFS, Morris Merrick, present Executive Director of DOCFS, Isaac Beaulieu, Chairman of the Board of DOCFS, and Ernie Daniels, past Executive Director of DOTC. Information was also found in the Hudson Report, and the Yellowquill Report.

When DOCFS came into existence, the structure was straightforward and clear. At the reserve level there was to be a local child welfare committee on each reserve that would consist of interested reserve residents. That committee would offer advice and information to the child care workers who worked on a particular reserve. For instance, the local child welfare committee could provide information about the families receiving help from DOCFS, and they could also provide information about cultural traditions or community values that might help the child care worker, in consultation with his or her supervisor, to decide on what type of action or assistance to take in any particular case. The committee could also initiate discussion about particular children, or child welfare matters generally. But it was clear at the outset that the ultimate decision about what action to take in a particular case would be the responsibility of the child care agency. That is, after receiving information and advice from the local child welfare committee, the DOCFS child care worker

would consult with his or her supervisor and decide what action to take. The committee would not make the decision, they would offer advice. The decision belonged to the child care agency. And that is the way the Child and Family Services Act reads. Although allowances are made for cultural differences, it is the responsibility of the child care agency to protect children within their mandate. DOCFS did work in this way.

There were to be four supervisors for the eight reserves served by DOCFS. Each supervisor had responsibility for two reserves. The child care workers hired for the reserves would be responsible to their supervisor. An executive director had overall responsibility, and supervisors would report to the executive director.

There was also to be a Board for DOCFS that would set policy for the agency, much in the same way that non-aboriginal child caring agencies have Boards. The Board was to consist of representatives from each of the local child welfare committees. The Board would not interfere in the day to day operation of the agency, just as the local child welfare committees would not dictate to child care workers what they should or should not do.

Child care workers and supervisors would be professional child care personnel. That is, they were expected to be just as qualified and professional as their counterparts in non-aboriginal child care agencies. If it

was necessary to hire people who were not as qualified as their non-aboriginal counterparts when the agency was in its infancy, these problems would be overcome with time. Education and qualification levels would be raised. Intensive ongoing training would be available, and generally, the standard of care from DOCFS would be expected to be at least equal to the standard prevailing at non-aboriginal child caring agencies.

The main difference between DOCFS, and a non-aboriginal child care agency, would be that aboriginal customs and traditions would be built into the DOCFS structure, and their method of operation. The local child welfare committee concept, for instance, recognized the importance of involving the community served, and also recognized the importance of incorporating aboriginal culture and traditions into their day to day operations.

The evidence that came forward at this inquest has convinced me that this structure has broken down at every level, and that there is confusion both within DOCFS itself, and confusion in the communities DOCFS serves. Even the present chief of the Sandy Bay Reserve, Angus Starr, did not have a clear understanding of how DOCFS was to operate on his reserve, and where DOCFS jurisdiction ended and the band council's began. He did not even know if there was a local child welfare committee functioning on his reserve (Claudia Houle testified that to her knowledge there had not been a meeting of the committee for at least two years). Chief

Starr thought it was perfectly proper for a band councillor to dictate to DOCFS when and how workers were allowed to apprehend children. So the confusion seems to go to the highest levels. Chief Starr is one of many witnesses who were hopelessly confused about how this agency was to operate and what it was to do.

Esther Seidl testified that when she became the Executive Director of DOCFS in January, 1985, she found that no DOCFS Board existed. According to Ms. Seidl, the chiefs of the reserves served by DOCFS had decided in 1984 for reasons known only to them that the Board should be disbanded, and they simply disbanded the Board, and it was no more. One of Esther Seidl's first decisions when she became Executive Director was to suggest that a Board (or Regional Committee) should be formed. Instead of reinstating the Board composed of representatives from the local child welfare committees, the chiefs foolishly decided that they would become the Board themselves.

Instead of giving communities more control over the child care matters, as envisioned by the chiefs, the exact opposite took place. Isaac Beaulieu described how the chiefs did not have time (and I suspect the necessary expertise or even interest) to deal with child welfare matters, and more and more decisions were being made by the Brandon head office of DOCFS. The child care system was becoming more centralized and the community was losing control. The local child welfare committees were more

confused about what their function was. They stopped meeting. Child care workers, who were not professional social workers, either looked to head office for answers, or tried to muddle through themselves. DOCFS was losing direction.

A change in administration took place at DOTC in 1988. Although the details of this are vague, some type of strangely selective purge took place. Non-aboriginal people were sacked. They were replaced by aboriginal people - but people who in many cases did not have the necessary expertise. For instance, at this time in 1988, Morris Merrick replaced Esther Seidl as Executive Director of DOCFS.

These changes did not solve the problems. Instead, more problems were created.

In the meantime the agency was wrestling with recommendations for changes made in various reports commissioned by DOCFS. The Hudson Report recommended some changes, other studies commissioned by DOCFS recommended others, and Ernie Daniels had his own agenda. Then along came the Yellowquill Report and garbled things even further, by recommending that local committees be given the power to give orders to professional child care workers. Confusion was piled on confusion.

This problem of confusion within DOCFS has led to many of the problems that were described at this inquest.

There was and is confusion about the role of the local child welfare committee, (now correctly called the local child and family services committee, or LCFS). Some workers described the committee as being an advisory body, that is, the committee would give advice to a worker about a case, but the ultimate decision to apprehend or not, would belong to the worker in consultation with the supervisor. Other DOCFS workers said that the committee actually made the decision. Other workers didn't know. For instance, Bill Richard said that if a supervisor wanted him to do one thing, and the committee wanted him to do another thing he would think about it, and make up his own mind.

There was and is confusion about the role of the supervisor. Some workers said that if a worker and a supervisor disagreed about a plan, the supervisor would have the final say. Some workers believed that if a worker disagreed with the opinion of a supervisor, the worker could carry on with the worker's plan in spite of the supervisor's opinion. Bill Richard, for instance, thought he was not acting incorrectly when he moved Lester Desjarlais to Winnipeg, knowing that his supervisor, Marion Glover, had specifically ordered Richard to leave Lester at his Sandy Bay placement.

There was and is confusion about the role of chief and council in child welfare matters. Cecil Desjarlais, a band councillor who held the child welfare portfolio for the Sandy Bay Indian Band testified that he interfered and "over

ruled" decisions made by DOCFS on more than one occasion, and that he was justified in doing so. He explained that as an elected representative, if a constituent asked him to intervene he had a responsibility to do so. His intervention could include orders to DOCFS to follow procedure that he made up on the spot, and his powers extended to the school as well. In fact, according to Mr. Desjarlais, anything that he thought might affect the rights of his constituents was within his jurisdiction, and he could take what action he deemed proper.

Mr. Desjarlais's opinion is clearly wrong, but there is confusion within DOCFS about this. Some workers, for instance, Bill Richard, believed that it was proper for Cecil Desjarlais to overrule decisions made by DOCFS, and to formulate procedure that DOCFS was to follow. In the event of a conflict between Mr. Desjarlais and a DOCFS supervisor, or the local Child Welfare Committee, Mr. Richard believed that he was at liberty to choose between the varying options.

To other DOCFS personnel the situation was less clear. According to workers such as Ron Mousseau, Mr. Desjarlais was not dictating DOCFS policy, and probably did not have the authority to do so; he was simply reacting to Marion Glover's incompetent or illegitimate decisions. Other DOCFS employees had positions somewhere between the opinions of Bill Richard and Ron Mousseau.

There was and is confusion about the role of the off-reserve worker and the supervisor. In the case of the conflict between Marion Glover as supervisor and Danta Kunzman, a Winnipeg off-reserve worker, over Annette and Lester Desjarlais, neither Danta Kunzman nor the DOCFS head office seemed to be clear about the power structure.

The confusion did not exist only among the lower level employees. In fact at one point Winnipeg counsel for DOCFS, Vic Savino, admitted that even he did not understand the decision making responsibility within DOCFS. (No. 44 of Exhibit 28)

At Sandy Bay, at some point, child care workers in consultation with their supervisors ceased to have the final say in child welfare decisions. One example given by Marion Glover involves the case of Donna Desjarlais. Because that case is a clear example of the breakdown and confusion I am referring to, it will now be examined in some detail.

I was initially very reluctant to allow in evidence about the case of Donna Desjarlais, because it is obviously not directly related to the case of Lester Desjarlais. However, I was convinced after hearing Marion Glover's testimony, that it was necessary to examine the case of Donna Desjarlais in order to properly understand what was going on at Sandy Bay and within DOCFS while Lester was a ward of DOCFS. I will examine this one case, the case of Donna, in detail. It points to the problems within DOCFS and surrounding DOCFS that I will then discuss.

(i) THE CASE OF DONNA DESJARLAIS

In a nutshell, Donna Desjarlais was apprehended by DOCFS because of sexual abuse concerns. The child was removed by her grandparents by force from the foster home where she had been placed by DOCFS, and the agency was unable to do anything about it. All attempts by the agency (or school for that matter) to have the child reapprehended or even assessed were thwarted. The child remains with the original guardians. So on the face of it, the agency was either incompetent, or impotent, or both.

Donna Desjarlais was a grade one pupil at Sandy Bay Elementary School when the sexual abuse was disclosed. Donna's teacher for the 1987 - 88 school year, Trudy Yu, testified that Donna was a beautiful little girl but a "severe, severe behaviour problem". Donna was totally disruptive in class and verbally aggressive, especially to females. One day Donna came into the class and took her clothes off. Written on her chest and abdomen were the words "Joe and Donna best lovers in Sandy Bay". It should be noted that this was not Donna's writing. Donna was just beginning to print. Samples of her printing found in her school files (exhibits 45 and 46), together with her teacher's opinion, make it clear that someone older had written these words on Donna.

Trudy Yu testified that Donna had taken her clothes off in this manner on previous occasions. She had also displayed other inappropriate behaviour, such as grabbing at her

crotch area and commenting about penises. Some of Donna's drawings had pictures of large penises (examples are found in exhibit 45). And Donna, at one time, had told Trudy Yu that she did not like it when she was left alone at her home because "Uncle Joe gets into bed with me". Joe Desjarlais was in fact related to Donna's guardians, Donald and Donalda Desjarlais, and was in fact often at the home. Trudy Yu was very concerned about Donna's possible sexual abuse.

Ellen Cook (then Haroun) was also a teacher at the Sandy Bay school when Donna was apprehended. She described Donna as a very sad and troubled child. Donna would lift up her shirt and point to her nipples. She would grab boys by the crotch and refer to their "hard ons". Ms. Cook asked Donna to draw a picture, and one of Donna's pictures was the picture of a man with a large penis. According to Ms. Cook, Donna said "this is Tuk Tuk with a hard on". According to Ms. Cook, Donna drew another picture of a man with a penis and Donna said that the man was "Uncle Joe". Donna told Ms. Cook that she hated these men, and hated being at home when they were there. Ms. Cook was of the opinion that Donna was being sexually abused.

Marilyn Barr also worked at the Sandy Bay school at the time as a resource teacher. Ms. Barr has a Bachelor of Arts, a Bachelor of Education, a Master's in Counselling, and extensive experience in teaching and social work. Her knowledge in the area of childhood sexual abuse is impressive.

Ms. Barr was seeing Donna in her capacity as a resource teacher. Her first impression of Donna was that she was almost uncontrollable. Donna would come to school unkempt and uncared for. Ms. Barr formed the opinion that Donna was a very unhappy and neglected girl. When Ms. Barr asked Donna to draw pictures for her, Donna drew pictures of stickmen with grossly enlarged penises.

Ms. Barr was firm in her opinion that Donna was being sexually abused. Ms. Barr was also of the definite opinion that the child should be apprehended. She explained her understanding of the proper procedure to follow in such a case. Namely, the child should be apprehended, and placed in a place of safety while investigations were being conducted. Planning for the child including treatment plans could be made when the dimensions of the problem were clear. A medical examination should take place as a part of the investigation, but it would not be surprising if no physical evidence of abuse was detected. The medical examination would certainly not end the investigation or be a reason by itself to return the child to the guardians.

The correctness of this basic procedure was confirmed by other witnesses at this inquest, including Dr. Charles Ferguson, who (along with Drs. Kenneth McCrae and Sally Longstaffe), is Manitoba's leading authority on child abuse.

Ms. Barr also gave her opinion that it would not surprise her at all if the child did not give a statement to the police detailing the sexual abuse. The important thing,

in Ms. Barr's opinion, was that the child should be removed from the possibly abusive home and placed in a safe home while the investigations were going on, and that the child be treated for the abuse.

The symptoms described by all three women were classic signs of possible sexual abuse, and they passed this information on to the principal.

Isaac Beaulieu suggests that Donna's behaviour may be accounted for in other ways. His suggestion is fetal alcohol syndrome. Dr. Blue's suggestion is the more general diagnosis of possible neurological problems. The two gentlemen might be correct. However, those problems would be in addition to the sexual abuse. It is very possible, and in fact almost certain, that Donna has serious problems, quite independent of her sexual abuse. The gross and classic signs of sexual abuse in this case make it clear that her sexual abuse may have highlighted or aggravated existing problems.

It was this information that was passed on to DOCFS by the school. This was not the first time that Donna's situation was discussed at Sandy Bay School. Trudy Yu, Marilyn Barr and Ellen Cook had discussed Donna before. They were very concerned about her. They had discussed her possible sexual abuse before. Marilyn Barr had noted how dirty and neglected the child was, as well as her unhappy state and her bizarre behaviour. It was not the first time that an older person had drawn on Donna's body. On one

occasion Donna appeared in school with a picture of a penis on her body.

However, it was the incident with Donna coming to school with "Joe and Donna best lovers in Sandy Bay" written on her body by an older person - in essence, a sign saying "I am being sexually abused", that made the teachers decide that they must ask DOCFS for immediate help.

That is precisely what DOCFS, under Marion Glover's supervision, tried to give. Bill Richard was instructed by Marion Glover to apprehend Donna. I will pause here to consider the decision Marion Glover made to apprehend Donna. Glover is strongly criticized by DOCFS, and the example of Donna Desjarlais is used by DOCFS as exemplifying Glover's incompetence, disorganization and confusion. As I see it the decision to apprehend Donna was the correct one. There was clear and worrying evidence of possible sexual abuse. There were indications from the school that they had been worried about Donna for some time, and that they had suspected sexual abuse before. The people named by Donna as her abusers both frequented the Donald Desjarlais home. (Ron Mousseau suggested that the "Joe" written on Donna's body might refer to someone other than Joe Desjarlais, but all credible evidence suggests that indeed it was Joe Desjarlais that was the "Joe" suspected of writing on Donna's body and abusing her). And "Tuk Tuk" was the youngest son of Donald and Donalda Desjarlais, and lived at their home.

Donna's situation had been discussed at the child abuse committee meetings before. Even Bill Richard, who practically had to be forced to act in Donna's case (and who later refused to file Donna's apprehension papers in court) admitted that the decision to apprehend Donna was the correct one. I can see no incompetence, confusion, or disorganization on the part of Glover in the decision to apprehend. She made the proper decision.

I will next look for evidence of incompetence, confusion and disorganization in the execution of the apprehension. Cecil Desjarlais complained in his letter to DOCFS (#54 of Exhibit 28) that the apprehension was botched, Donald and Donalda Desjarlais were not notified, and the school was not told that Donna was being taken. That is not what Bill Richard says. Richard was the DOCFS worker who apprehended Donna. He says that he first advised Donalda Desjarlais that Donna was going to be apprehended. He then went to the school and apprehended the child. It should be remembered that it was the school personnel who asked DOCFS for help in the first place. They were not surprised by Mr. Richard's apprehension. They were very relieved that their request for assistance had been acted on.

Bill Richard took Donna to the home of Claudia Houle. That placement had been previously arranged. Ms. Houle's home is on the Sandy Bay Reserve, and was approved by DOCFS as a foster home. Again, I look for evidence of Glover's incompetence, confusion and disorganization in orchestrating

the apprehension, and I can find none. In fact, everything was done quite well.

Donna was not allowed to go home before being apprehended. Glover knew that the Donald Desjarlais family had fiercely resisted intervention by DOCFS in the past, in the case of Annette Desjarlais. She also knew that "Tuk Tuk" and "Uncle Joe" might be at the home. It was quite reasonable to worry that any statement from Donna might be jeopardized if Donna first went home before being apprehended.

The claims by Donald and Donalda that they had no notice that Donna had been apprehended were false according to Bill Richard. He gave notice to Donalda Desjarlais. Isaac Beaulieu produced that notice of apprehension that had been served on Donald and Donalda Desjarlais. Similarly the claim that the school was not told that Donna was being taken by DOCFS was false according to Richard. Richard told the school what action DOCFS was taking. The school had in fact requested action from DOCFS.

I can find nothing wrong with the actions of Glover, or DOCFS under Glover's direction to this point. Donald and Donalda's rights had not been violated by DOCFS.

But the Desjarlais family was certainly hopping mad. It is clear that Donald Desjarlais enlisted the support of Cecil and other influential reserve residents, and they decided that they were not going to let Donna be apprehended. They succeeded in thwarting the apprehension.

It was not because of Glover's "incompetence, disorganization and confusion" that they were angry. It was because of Glover's decision to apprehend. They did not want DOCFS to intervene. They wanted to be left alone.

This attitude is not that unusual. A family confronted with planned intervention by a child care agency can be expected to be upset. But the amazing thing here is that the Desjarlais family got away with it. In spite of Glover's efforts to follow through with the apprehension, the rest of DOCFS caved in to this pressure from the Desjarlais family.

It should be noted that if a person or a family disagrees with the actions of a child care agency they have remedies available to them. The Desjarlais family could have contested Donna's apprehension in court. In addition, on DOTC reserves, aggrieved people can bring the matter to the attention of the local child and family services committee or the Board of DOCFS (Regional Committee) for review. But these remedies were not pursued. Instead the Desjarlais family "over ruled" the DOCFS decision by force, and DOCFS allowed them to get away with it.

I will back up a bit at this point to detail exactly what happened after Donna was apprehended from the school.

The accounts concerning the apprehension of Donna, and what happened afterwards differ somewhat from witness to witness, but I have pieced together their stories in order to build a description.

This is what happened: Donna was taken to the Claudia Houle home. Cst. Randy McGinnis of the Amaranth RCMP was interviewing Donna, and although Donna was "talking in circles" the constable was making headway. Donna was talking freely with the officer. Bill Richard was present. Suddenly Donna's grandmother, Donalda Desjarlais barged into the home with two of her adult sons. Donna was clearly intimidated by this, and Cst. McGinnis was not able to get any more from Donna. A loud argument ensued, and the constable was worried that he would have to use force. Bill Richard talked to Donalda. He told her that he had to take Donna to a medical doctor in Gladstone the next day for an examination. If the examination showed no evidence of sexual abuse Richard cravenly promised that Donna would be returned to Donalda. Donalda and her son left the Houle home. Cst. McGinnis and Bill Richard left shortly after, believing that Donna was safe. Donalda returned later that day and took Donna from Claudia Houle's home.

The next morning the medical examination took place at Dr. Macklem's in Gladstone. It is not known whether Dr. Macklem has special training in sexual abuse. Medical training alone does not qualify doctors to give opinions about sexual abuse. Both Cst. McGinnis and Bill Richard were present. They were under the impression that Donna had spent the night at the Houles. Immediately after Dr. Macklem gave his opinion that he could find no physical evidence of sexual abuse Richard returned Donna to Donalda.

This is the interpretation of the events that is most favourable to Bill Richard. The less favourable interpretation is that after Cst. McGinnis left the home, believing that Donna would remain there for the night, Donalda returned and Richard allowed her to take Donna. Claudia Houle made it very clear that Donna did not remain at her home that night. When asked this important question at the inquest she paused, looked straight at me, and said clearly and slowly that Donna had not spent the night at her house. Bill Richard's behaviour throughout this whole episode shows a child care worker much more concerned with the political fallout from his actions than the welfare of Donna.

Bill Richard admitted that he knew practically nothing of the information from the school pertaining to Donna. He had not been Donna's worker. He was simply instructed to carry out the apprehension and see that Donna was examined by a medical doctor. His decision to return Donna to Donalda was based not on good information, but instead on fear of the Desjarlais family. He was looking for an excuse to return Donna. He knew that Glover wanted a medical examination done as a first step only, and he knew that Glover did not want Donna returned to Donald and Donalda's home, but he took it upon himself to return the child to avoid further confrontation with the Desjarlais family.

This is not the only example given at this inquest of DOCFS forgetting that the best interest of the children they

are to protect is paramount, but it is a graphic example. Richard knew practically nothing about the information upon which the apprehension was based, but he was so anxious to return the child and avoid further trouble that he seized upon Dr. Macklem's opinion that there was no physical sign of abuse and rid himself of the problem.

In fact, a medical examination is a first step in dealing with a child who has possibly been sexually abused. It is not at all surprising that Dr. Macklem could find no physical sign of abuse. But that is certainly not a reason by itself to return the child. Richard's statement that the opinion of the medical doctor that there were no physical signs of sexual abuse was a satisfactory reason for returning the child in this case where other indicia of abuse was so strong was evidence of incompetence. Even a person with only elementary understanding of sexual abuse cases would not make such a statement. Yet Richard is given the title and responsibility of a child and family services worker. This is a glaring example of what is referred to later as the need for qualified professional child care personnel at DOCFS.

This also points to a problem within the medical profession noted by Dr. Charles Ferguson. Medical doctors with no specialized training in sexual abuse insist on giving expert opinions in spite of their lack of expertise. They do not appear to understand that their opinion are given great weight by the public generally and by other

professionals. The people that rely on the opinion of medical doctors assume that the doctors are qualified to give their opinion. Recommendation #1 at page 251 of this report deals with this problem. I also strongly suggest to the medical profession that it is incumbent on the profession to address this problem internally. Only doctors who are qualified to give opinions about sexual abuse should do so.

This is not to be taken as a criticism of Dr. Macklem. His credentials were not examined at this inquest. I will return now to the description of Donna's care.

After Richard returned Donna to Donald and Donalda, Glover did everything she could, first to re-apprehend Donna, and when that proved to be impossible, to try to have Donna assessed by Dr. Ellis. The other people involved at DOCFS did everything they could to prevent Glover from succeeding.

The task of filing documents in court for Donna's apprehension was given to Bill Richard (an application must be made to court within four juridical days of the child's apprehension). Richard did not do it. He explained in court that he refused to file the papers because of Dr. Macklem's opinion. Again, Richard admitted that he had only a vague idea of the school information about Donna. He did not trouble himself to find out more before going against his superior's instructions.

Richard received a disciplinary letter for not filing papers. But what it meant for Donna was that the apprehension was illegal and would have to be redone. By that time Donna had been back in Donald and Donalda's home for some time, and the possibility of gathering information from Donna about her abuse was fading.

Glover's attempts to have Donna re-apprehended after this failed. She tried. The Amaranth R.C.M.P. advised her (correctly) that the DOTC police were responsible for assisting DOCFS with apprehensions on the reserve. The DOTC police informed Glover (also correctly) that they would assist only if a DOCFS worker attended at the residence with them. The Sandy Bay DOCFS workers refused to do this.

I suppose that Marion Glover could have attended at the residence with DOTC police. It would be extremely unusual for a Brandon supervisor to do this, but it could be done. I find it hard to fault Marion Glover for not taking this step. She was meeting with opposition at every turn. She was afraid of Donald Desjarlais for good reasons. He was an extremely volatile man, and in fact on a later occasion met Marion Glover with his rifle pointed directly at her. I do not fault Marion Glover for concluding that she was getting nowhere with her attempts to re-apprehend Donna. None of the DOCFS workers would attend at the Donald Desjarlais home. They were afraid of the Desjarlais family.

Glover next tried to have Donna seen by Dr. Eric Ellis. Dr. Ellis is a recognized expert in such matters, and

Glover's decision to have Dr. Ellis involved was appropriate. But Dr. Ellis never did see Donna. The claim by DOCFS that Donna did not see Dr. Ellis because of disorganization on the part of Glover is false. By this time DOCFS workers were actively working against Glover's plans to do something about Donna. Ron Mousseau sabotaged the appointment with Dr. Ellis. In fact, Dr. Ellis was so fed up with DOCFS cancellations and other similar problems, that he withdrew his services from the agency. Attempts by Elaine Scott and Ron Mousseau to blame Glover for the cancellations of Donna's appointments are without foundation. Glover was trying to have Donna assessed by Dr. Ellis. The other DOCFS workers had given in to pressure from reserve residents and were working against Glover's efforts. Glover lost. Donna was not re-apprehended. She was not properly assessed. No treatment was given.

Whether or not Donna is currently at risk is not the business of this inquest. I have spent this time examining Donna's case because it clearly points to many of the problems DOCFS is experiencing. In Donna's case, the Desjarlais family simply overpowered DOCFS.

An agency cannot carry out its mandate if some families on a reserve are off limits. That is what the case of Donna clearly demonstrates. Donna, the grandchild of Donald, who was the chief's brother, and Cecil Desjarlais's uncle was declared off limits. DOCFS meekly gave in to this declaration. It now tries to justify its weakness.

DOCFS alleges that Marion Glover was culturally insensitive in the case of Donna Desjarlais. Dr. Art Blue suggests that native communities can deal with abuse situations in ways other than by removing the child from the home. DOCFS now says that maybe the child should not have been taken from Donald and Donalda Desjarlais. They may have found ways to keep the abusers from Donna, and Donna would have been better off.

In fact, if the apprehension had been allowed to proceed properly, the final result may have been to remove the abusers from the home, and return Donna to the home of Donald and Donalda Desjarlais, perhaps with supervision. That will never be known. Donald and Donalda Desjarlais, with the help of reserve residents, and acquiescence from DOCFS workers, prevented plans like this from being considered.

It is not reasonable to suggest that the child should simply have been left at Donald and Donalda's home after these serious allegations of sexual abuse came to light. The actions of Donald and Donalda Desjarlais after the apprehension, and their previous behaviour in the case of Annette, made it clear that their co-operation with the agency was extremely unlikely. Protection of the abusers, as opposed to protection of the child, was likely to be the response. Sexual abuse of children is not tolerated within aboriginal tradition any more than it is tolerated by non-aboriginal society. Taking no action in the face of the

evidence in the case of Donna Desjarlais would be negligence, whether the Child care agency was aboriginal or non-aboriginal.

In conclusion, the decision by Marion Glover to apprehend Donna Desjarlais was reasonable under the circumstances. Ms. Glover was concerned with the protection of the child. The response of Donald and Donalda Desjarlais, Cecil Desjarlais, and others within DOCFS, showed more concern for protecting adults.

The closing summary on Donna Desjarlais's DOCFS file (exhibit 27) gives as reasons for closure

> "RCMP concluded their investigation. No corroborating evidence to substantiate sexual abuse. No further concerns with family".

Under "service provided by agency" the following comments are made

> "child placed under apprehension for a medical examination by Dr. Macklem - no physical evidence of abuse - psychological assessment by Dr. Blue - no indications to substantiate sexual abuse".

The closing summary definitely gives the impression that Dr. Blue concluded a thorough psychological assessment on Donna to deal with the sexual abuse allegation, and no evidence was found. In great part on the strength of Dr. Blue's report, and because the RCMP had concluded their investigation, the file was closed.

That is not the evidence of Dr. Blue. He testified that his report was very preliminary in nature. He found

many serious problems with Donna, and he expected that DOCFS would refer Donna to others for further testing, such as neurological testing.

A more serious objection still to the attempt by DOCFS to justify closing Donna's file on the strength of Dr. Blue's interview, is the fact that Dr. Blue saw Donna before the most dramatic suggestion of sexual abuse came to light, that is, the writing of "Joe and Donna - Best Lovers on Sandy Bay" on Donna's body that prompted the school to request immediate action by DOCFS. Dr. Blue saw Donna on February 11, 1988, two weeks before this incident occurred. He was dealing with previous school concerns and did not have the new evidence before him.

But fatal to the DOCFS attempt to justify closing Donna's file on the strength of Dr. Blue's report is this: Dr. Blue is not in any sense an expert in the area of child sexual abuse. Dr. Charles Ferguson, in a kind but clear way, explained why Dr. Blue is not qualified to involve himself in the field of sexual abuse. Dr. Blue is stepping out of his area of expertise when he offers opinions about sexual abuse. Dr. Ferguson testified that too many professionals - medical doctors, psychologists and others, are far too ready to give expert opinions about sexual abuse when they simply lack the expertise to do so.

In fact, arrangements had been made by Marion Glover to have Donna assessed by Dr. Eric Ellis, who is an acknowledged expert in the field of child sexual abuse. Dr.

Blue was unaware that when he interviewed Donna, arrangements had already been made for Donna to see Dr. Ellis. Dr. Blue also did not see Marion Glover's letter to Dr. Ellis dated April 13, 1988 (No. 55 of Exhibit 28). That letter contained useful information that might have been of assistance to Dr. Blue. Dr. Blue was also not given the proper background information about Donna that was available to DOCFS. Even if Dr. Blue had had the necessary expertise to give his opinion, he had not been given the necessary material by DOCFS.

For reasons not explained by DOCFS, Marion Glover's letter (No. 55 of Exhibit 28) was not in Donna Desjarlais's DOCFS file (Exhibit 27). What is just as odd, Marion Glover was not aware that Dr. Blue had been asked to see Donna. Marion Glover was not aware after the interview that Dr. Blue had seen the child. She had not been told by her co-workers.

At the time of Dr. Blue's interview of Donna, Marion Glover was the supervisor responsible for Donna's file. Someone other than Marion Glover was making arrangements in the case of Donna's file. It is not known who was giving these directions. It is also clear that someone other than Marion Glover was responsible for sabotaging Donna's appointment with Dr. Ellis. DOCFS makes much of the fact that Marion Glover was responsible for one foul-up of an appointment with Dr. Ellis. However, that occurred on one occasion only, and was a pure mistake. The missed

appointments that caused Dr. Ellis to withdraw his services from DOCFS were mainly due to deliberate cancellations and sabotage by someone within DOCFS. (The cancellations were not continued to the case of Donna by any means). Ron Mousseau was involved, but it is not clear who was pulling the strings. It is clear that Marion Glover, who was still the supervisor responsible, was trying to have Donna re-apprehended, and then when she met with no success, she was trying to have Donna assessed. Others within DOCFS and at Sandy Bay were deliberately frustrating these plans.

One of the most absurd claims made by DOCFS about Marion Glover at this inquest is that Ms. Glover refused to continue the court proceedings pertaining to Donna, and that Marion Glover sabotaged Donna's appointment with Dr. Ellis. A phone call to the Child Protection Centre from Ms. Glover during this period of time was noted. Ms. Glover was almost desperate for some type of action to be taken in Donna's case. For DOCFS to claim that it was because of Marion Glover that no action was taken is disneyesque.

Dr. Blue's assessment was used as an excuse to close Donna's file. As noted, that was not the intention of Dr. Blue, who regarded his assessment as very preliminary, and expected DOCFS to arrange further testing. The closing summary looks very much like a manufactured excuse for closing a difficult file. To say that there were "no further concerns with the family" in light of the evidence

is incredible. There certainly were concerns. DOCFS chose to ignore them.

In order to prevent this inquest from continuing indefinitely, I made rulings during the course of the proceeding designed to keep the issues discussed as close as possible to the circumstances of death and the questions from the Chief Medical Examiner and the Ombudsman. One of these rulings had to do with Donna. I ruled that Donna's current status, that is whether or not Donna is now in need of protection was not the business of this inquest. I understand that the Ombudsman is pursuing this issue. But what happened in Donna's case after her file was closed on August 16, 1989 is relevant to the inquest for some purposes quite apart from the question of Donna's present status. Considerable time was spent at the inquest dealing with referrals that had been made to DOCFS after Donna's file was closed, but which were not placed on Donna's file. For instance, Patrick Hannah was a teacher at Sandy Bay who worked with Donna. Donna told Mr. Hannah in January, 1990, that she had been watching porn movies and drinking beer the night before. Mr. Hannah referred this information, via the school committee, to DOCFS. This referral was not on Donna's file and the file remained closed. Similarly, Dr. Ron Richert phoned DOCFS well after the file was closed and expressed concerns about Donna, and yet this information was not placed on Donna's file. There are other examples as well of referrals about Donna to DOCFS that should have been

investigated, and should have been noted on Donna's file. It was only when the existence of the new file (Exhibit 107) became known in the next to last days of the inquest that this mystery was solved. The referrals, at least the school referrals, were on that new file.

In fact there were new sexual abuse related concerns pertaining to Donna discussed in that file. Donna, then eight, told a male DOCFS worker that she had been having sexual intercourse with another boy. She asked the male worker, (who did not refer the matter at that point to a trained sexual abuse worker, preferably female), whether he "fucked his girlfriend in the ass", and other similar revelations, extremely disturbing for a girl of that age. The discussion and what it revealed was, in my opinion, more troubling than the revelation that she had been having "sexual intercourse" with an older boy.

The Director made a point of stating through counsel that he had given the inquest everything that had been requested. The new file, Exhibit 107, could not be requested because its existence was not known to the inquest until Bev Flett revealed its existence on June 22, 1992. The Director knew of its existence when he testified at the inquest on June 16, 1992. He was asked questions about Donna's case - he had the opportunity to tell the inquest about the file's existence. He made no mention of it. In my opinion, he had a duty to do so. The excuse that he was not specifically asked to provide this information might be

acceptable for an ordinary person on trial for a criminal offence, but not for a person in Mr. Bakken's position. I will comment further about this witholding of vital information further on in this report.

As for DOCFS, until the new file was discovered (only because a senior DOCFS employee, Bev Flett, decided to come forward and voice her concerns) DOCFS had spent a great deal of time and energy at the inquest making excuses for the fact that the referrals were not on the file. Isaac Beaulieu spent hours discussing how the DOCFS method of dealing with files would involve a group, consensus approach, with NADAP workers, school personnel and DOCFS workers constantly consulting about the case although nothing was noted in the file, and how this was part of the "native way" ( and other such claptrap). It was evident when this file was discovered, with the hitherto missing referrals on that file, that Mr. Beaulieu had simply been making this up. He was extremely embarrassed by the fact that he had not been told about this new file as well he should be. But his elaborate explanations about why the referrals were not on Exhibit 27 had been proven to be nothing but hot air.

The overall response of DOCFS (with the notable exception of Marion Glover) in the case of Donna Desjarlais convinces me that their first priority was not the welfare of Donna. Their priorities were elsewhere.

After this inquest adjourned last fall, Marion Glover repeated her allegations about Donna to the media. She alleged that Donna might still be at risk. Newspaper articles were printed carrying this story, and the Director was forced to investigate Donna's living situation, and prepare a report. That report, and appendices, were filed as Exhibits 53(a) and 53(b), respectively, at this inquest.

The Director assigned the task of investigating Donna's current situation to Evelyn Mathers, an experienced social worker, who works within his department in a middle management position. Specifically, Mrs. Mathers was asked to provide a report to the Director giving her opinion on whether or not Donna was currently in need of protection. Mrs. Mathers investigated Donna's situation, and concluded that Donna was not in need of protection at the time of Mrs. Mather's visit to Sandy Bay on January 9, 1992. As this inquest is not dealing with the question of whether or not Donna is currently in need of protection, Mrs. Mather's conclusion is neither here nor there to this report. However, because Mrs. Mather's report was one of the items the Director apparently used to formulate his opinion that DOCFS had properly investigated and handled Donna's case in 1988 (found in Exhibit 53(b)) and that the Director did a proper job in 1988, it becomes necessary to look briefly at the investigation done by Mrs. Mathers.

Mrs. Mathers arrived at Sandy Bay on January 9, 1992. She had intended to interview Donna's caregivers and go to

Donna's home, as well as to observe Donna in a classroom setting and interview DOCFS workers, and Sandy Bay School personnel working with Donna. This proved to be impossible. Donald and Donalda Desjarlais had apparently not been prepared for the visit of Mrs. Mathers. It appeared to Mr. and Mrs. Desjarlais that Evelyn Mathers was an outsider who might be connected to a non-aboriginal child care agency. To Mr. and Mrs. Desjarlais this meant only one thing - that Mrs. Mathers was there to apprehend Donna. When Mrs. Mathers realized that her visit was causing a great deal of anxiety on the reserve, she wisely (in my opinion) decided to cut her visit short. She testified that if Donald and Donalda Desjarlais were to be interviewed, some preparatory work would have to be undertaken.

Unfortunately, for reasons not explained at this inquest, no such preparatory work was done. Mrs. Mathers never did interview Donald and Donalda Desjarlais. She did not go to their home, so she could not answer basic questions, such as who lived at the home, and specifically did the uncles suspected of sexually abusing Donna live there, or have access to the home. Mrs. Mathers did not talk to Donna at all, or observe Donna in a classroom setting, or at home. Mrs. Mathers did not examine the DOCFS file, before, during or after her visit to Sandy Bay. Mrs. Mathers, or anyone else at the directorate, did not know about the existence of the new abuse file on Donna (Exhibit 107) at this time, and did not find out about the existence

of the file until June 2, 1992. I am not sure that the existence of the new file would have made any difference to Ms. Mather's report. She did not examine the existing DOCFS file on Donna (Exhibit 27) and there is no reason to suppose that she would have asked to examine the new file if she had known about its existence.

She did speak with Donna's current teachers and the DOCFS worker who was familiar with Donna's case. Donna's DOCFS file had been closed by DOCFS on August 16, 1989 so there was no DOCFS material since that date in any event.

It is clear why Mrs. Mathers chose not to take the basic steps on January 9, 1992. It is unclear why she did not follow up after that date. The investigation she did carry out could just as easy have been done by telephone. It was more in the nature of a "check-up" than a "review". This is not meant as a criticism of Mrs. Mather's report per se. As previously stated, the task given to Mrs. Mathers was to determine whether or not Donna was currently in need of protection, an issue that does not concern this inquest. However, as far as the value of that "review" as it relates to the question of how DOCFS or the Director handled Donna's case is concerned, I conclude that the review done by Evelyn Mathers is of no assistance.

Similarly, I will not examine Exhibits 53(a) and (b) in detail in this report. Needless to say, I disagree with the conclusion that Lester and Donna's files were handled properly by DOCFS. The information given to the directorate

by DOCFS was not the same information that came out under oath at this inquest. It was information, at best, with a "spin" on it, and at worst, it was skewed. As stated, the Director did not know of the existence of the new abuse file on Donna that had been opened by DOCFS in January, 1990 (Exhibit 107). The existence of that file was not made known to the Director until June 2, 1992. The reason it came to the attention of the Director was due only to Bev Flett's integrity. But again, for reasons which I do not understand, the Director did not even ask to see the DOCFS file on Donna that he knew about (Exhibit 27). So there is no reason to suppose that he would have asked to see the new file (Exhibit 107) if he had known about its existence. He simply asked DOCFS for a "report". In addition, Marion Glover was not part of the Director's review, nor were many other witnesses that have appeared at this inquest. I will make comments later in this report about what I see as an approach by the Director that is far too cautious, but at this point I will simply state my conclusion that DOCFS did not handle the files of Lester and Donna properly. The Ombudsman is at present actively pursuing Donna's current situation, and the adequacy, of the Director's review.

A final sad note about Donna is the information that the little girl may now be pregnant. Bev Flett told the inquest that a reliable person from Sandy Bay had passed this information on to her, but Ms. Flett did not want to reveal the identity of that person. Marion Glover told the

inquest that she had heard the same news from another source. Isaac Beaulieu undertook to verify the pregnancy but was not able to do so, and I decided not to pursue the subject. My main reason is to avoid adding any more stress to the life of this tortured child.

(ii) RELATED CASES

This ends my examination of the case of Donna. This also concludes my description of the confusion within DOCFS. My conclusion is simple: Hopeless confusion existed within DOCFS when the cases of Lester and Donna were active. The testimony of witnesses, notably the testimony of Ella McKay and Bev Flett, convinces me that hopeless confusion exists within DOCFS at the present time. Lines of authority are not clear. The purpose of fundamentally important components of the system, such as the local child welfare committees, are murky in the extreme. The agency's responsibility to band councils is understood by the different people in different ways. In short, anarchy prevails, and confusion is the order of the day.

I have taken considerable time examining Donna's case, because it is contemporaneous with Lester's case and highlights exactly the same problems. In my opinion the case graphically illustrates both the weaknesses within DOCFS, and the problems surrounding DOCFS. But the cases of Donna and Lester were not the only case examples given at this inquest.

The case of the Whitford-Houle-Lavasseur children was discussed in detail at this inquest. In many ways it is an even more dramatic example of every one of the problems shown by the case of Donna.

In Whitford, children gave statements to well known R.C.M.P. Cpl. (then constable) Cathy King. The children

told of horrible sexual abuse by a number of adults, that included carrots and other objects being thrust into their vaginal and anal orifices, and also other atrocities. Cpl. King detailed this information in a thirteen page report and referred it to Marion Glover. Ms. Glover began planning for these children. The local child welfare committee, and the DOCFS head office in Brandon were included. Cecil Desjarlais and Ron Mousseau put a stop to the plans. After Marion Glover was fired DOCFS did nothing of substance about the case for at least eight months despite repeated requests, and finally demands, from the R.C.M.P.

To me the most notable aspect of the Whitford case is that it is almost a legend within DOCFS - the theme of the legend being that Marion Glover was so obsessed with sexual abuse that she was going to rent a van and apprehend thirteen children. In fact, within DOCFS this case is considered a standing joke, and proof that Marion Glover is extremely odd. DOCFS witnesses, with the sketchiest knowledge of the facts of this case, including their Winnipeg lawyer, hoot about Marion Glover's attempts to apprehend these children. The DOCFS version of the case has obviously been discussed with laughter whenever Marion Glover's name was mentioned.

But an examination of the R.C.M.P. file on Whitford, and the evidence that emerged at this inquest, reveals a case that is not funny at all. A very well respected R.C.M.P. officer detailed a gruesome case of child sexual

abuse. The officer asked DOCFS to do their job. Marion Glover tried. The rest of DOCFS, and the Sandy Bay community, would not let her do it. It was Ron Mousseau who personally stopped the apprehension from taking place. Cecil Desjarlais "represented" Sandy Bay.

A proper description of the Whitford case would take at least one hundred pages. To prevent this report from becoming impossibly long I will leave that task to someone else.

The cases of Annette and Allison Desjarlais were discussed in some detail at the inquest. Allison is Lester's younger sister. She was used for sexual purposes by her own grandfather, raped by her uncles, beaten and intimidated by her own family, mistreated by her own community, allegedly sexually abused by the supervisor of the agency that stepped in to "protect" her, and then bounced around from one foster home to the next, willy-nilly, with no long-term plan, by the same agency. By this time I had no confidence in DOCFS and consequently, I sent that file to the Director for the formulation of a proper plan for the child, and as assurance that she would receive attention from skilled social workers.

Annette told so many stories of physical and sexual abuse that it was not possible to sort out which ones were true, and which ones were imagined. But it is clear that she was a very troubled girl, and DOCFS was content to wait

for a crisis and then do short-term planning, with no apparent master plan at all.

Other cases offered as examples of the problems within DOCFS and within Sandy Bay were touched on as well. I have chosen not to detail these cases in this report.

For the same reason, I will not discuss in any detail the case examples offered to the inquest by Joyce Wasicuna. These cases took place mainly at the Sioux Valley Reserve when Joyce Wasicuna was employed by DOCFS as a protection worker. In general, these cases highlight all of the problems evident in the cases of Lester and Donna. Although I will not include descriptions of the cases in this report, with the exception of the examples included on pages 211 and 212, I will comment briefly about Joyce Wasicuna and the role that she played at this inquest.

Joyce Wasicuna described herself as a traditional native person. I would describe her as a woman of grace. It may be that Mrs. Wasicuna was the single most significant witness who testified at the spring segment of this inquest. I noted earlier that Marion Glover was the most significant witness in fall, and in fact responsible for this inquest becoming much more than a simple inquiry into the death of a child. But it was Joyce Wasicuna's testimony that I believe caused other witnesses, such as Ella McKay and Bev Flett, to come forward out of concern for children. Joyce Wasicuna came to the inquest at a time when DOCFS was still insisting that the only problems at DOCFS were those caused by Marion

Glover. Mrs. Wasicuna had faced threats and intimidation while employed by DOCFS. She risked the censure of DOCFS and others within her community by testifying. However, she came forward and gave a candid account about what it was actually like to work at a DOTC reserve community. The evidence she gave corroborated the evidence given by Marion Glover in fall. This is very significant, because until that point DOCFS could claim that Marion Glover was an eccentric outsider and not worthy of belief. Joyce Wasicuna single handedly changed that, and indeed changed the course of the inquest.

From that point on DOCFS could no longer claim (although they insisted on continuing to try to do so) that the problems described by Marion Glover were not real ones, or were simply created by one person. Joyce Wasicuna described the same problems.

To do justice to Mrs. Wasicuna's evidence, I would have to extend the length of this report considerably I have decided that this report is long enough. However, it occurred to me while listening to Mrs. Wasicuna that the problems detailed at this inquest would not be so severe if more people like Joyce Wasicuna, Ella McKay and Bev Flett were in positions to make child welfare decisions while others like Morris Merrick learned from these women.

(iii) SOLUTIONS TO THE CONFUSION PROBLEM

I will end any further discussion of the other cases raised at this inquest with the observation that several themes emerge from every one of those cases, and these themes are repeated over and over again. They are as follows:

- There is political interference in the day to day operation of DOCFS on the reserves and it seriously hampers their ability to protect children.
- The social problems existing on reserves are enormous, and the general community response is one of denial.
- The Director is virtually absent from the picture.

I will discuss these themes in order in the following chapters, but I will now return to the theme of confusion within DOCFS, and make recommendations for change.

I am not the first to note confusion as a major problem within DOCFS. The Hudson Report (73L) noted in 1984 that although staff accountability was specified in the policy manual, in practise they found evidence of confusion (at p.xi.). They also found "some evidence of confusion and conflict between local and regional levels" (also at xi.), that is between the local child welfare committees and the DOCFS Board (Regional Committee).

But it was in the Yellowquill Report (73(e) ) which was delivered to DOCFS in 1988 that the confusion problem was discussed in detail. By this time, the DOCFS Board had been disbanded by the chiefs. (This was done shortly after the

Hudson Report was issued, although I am certain that Dr. Hudson would have strongly disagreed with this decision). Confusion within the DOCFS organization was a major theme of the Yellowquill Report. That Report is very valuable to this inquest because it was conducted only months after Lester died, and the problems that it describes are the same problems described at this inquest. Page 16 of Yellowquill is reprinted here:

> 5. There is a general lack of communication and clarity of relationship between D.O.C.F.S. Brandon, D.O.T.C. Board and the eight communities in regards to child welfare services and issues.
>
> a) Most respondents reported frustration and confusion at the lack of clarity in regards to lines of accountability and reporting protocol.
>
> b) Respondents indicated a need to formalize relationships between D.O.T.C., D.O.C.F.S. senior management, local workers, supervisors and Local Child Welfare Committees in regards to child welfare services and organizational issues.
>
> c) Respondents indicated that no clear and consistent guidelines exist to suggest who is responsible to whom. This confusion exists at all levels within D.O.C.F.S.
>
> d) Responses from local workers, chiefs, councillors and committee members cited that a general lack of communication has contributed to many different interpretations of the role and function of Local Child Welfare Committees.
>
> e) Local workers reported confusion as to their relationship to the Chief in regards to decision making on child welfare matters. Ultimately who should

> they take direction from - Chief or supervisor? Workers reported that this left them in a situation where conflict between Chiefs and supervisors was possible.
>
> f) Chiefs and Councillors reported that D.O.C.F.S. Brandon strictly dictates policy following a narrow interpretation of provincial guidelines with no opportunity for discussion and modification from the community.
>
> g) It was reported that in some instances when problems have arisen between D.O.C.F.S. and community members and contact has been initiated with D.O.C.F.S no response was forthcoming.
>
> h) The history, philosophy and principles underlying the creation of D.O.C.F.S. have not been adequately communicated to the staff and communities which has resulted in a program that many people have difficulty differentiating from a Children's Aid Society.
>
> i) The principle of assisting band members wherever they reside is not evident and virtually all respondents indicate a lack of knowledge of what the off-reserve services are, why they exist, and how they impact on local communities and their members. Communication between the communities and the off-reserve workers is inadequate.

These were problems that existed on all eight reserves. They were not confined to Sandy Bay. These problems had started long before Marion Glover was employed by DOCFS, and continued after she was fired. The problems grew worse between the time of the Hudson Report (1984) and Yellowquill (1988). The steps taken by DOTC and DOCFS leadership between 1984 and 1985 only exacerbated existing problems.

Instead of acting on the recommendations made by Dr. Hudson, the chiefs took steps that were exactly opposite to what Dr. Hudson was recommending.

I will discuss the lack of a policy and procedures manual in more detail further on in this chapter. But briefly, Dr. Hudson stressed the extreme importance to DOCFS of developing a policy and procedures manual. They did not do it. Yellowquill repeated this plea. Again, DOCFS ignored it.

The decision made to disband the DOCFS Board was similar. In 1985, just after the release of the Hudson Report, the chiefs disbanded the DOCFS Board (Regional Committee). The Board had been one of the pillars of the DOCFS organizational structure. The concept of the DOCFS Board, composed of representatives of each of the eight local child welfare committees, had been praised by Dr. Hudson, former DOCFS Executive Director Tim Maloney, and other knowledgeable people. The disbanding of the DOCFS Board added to the serious problems within the organization. This decision was just plain foolish.

Isaac Beaulieu does his best to convince this inquest that DOCFS has seen the error of its ways, and has now solved its major problems. James Bakken, an Assistant Deputy Minister within the Department of Family Services, and Director of Child Welfare from 1987 - 1990, hints broadly that the inquest is dealing with problems that may have existed in 1988, but which are now well on the way to

being solved. This is definitely not the case. Witnesses like DOCFS worker Bill Richard, who in 1992 had no idea of what the lines of authority are within DOCFS, or the many different interpretations of the role of the local child welfare committee put forward by DOCFS employees even at senior levels and by community residents, right up to the Chief of Sandy Bay, convince me that these problems are still there.

But it was the testimony of Bev Flett and Ella McKay that conclusively proved that all of these problems are not only still plaguing the agency, they are even more serious now than they were in 1988. Bev Flett is an Assistant Executive Director of DOCFS. Ella McKay is a Senior Supervisor. Both women have been with DOCFS since its very beginning in 1981. They have risen through the ranks and are highly respected employees. In fact, Bev Flett was about to be promoted to a new position within DOCFS before she came forward to testify.

Both women came to the inquest in the final days of hearings. Their motive was a strong belief that DOCFS was not meeting its mandate to protect children, and that it was their duty to come forward and tell the truth as they saw it regardless of the consequences to them.

They told of an agency that was unable to function because of its internal confusion and disorganization. They described political interference that made it impossible for workers and supervisors to concentrate on child protection.

In short, they confirmed all of the serious problems that had been described by Marion Glover, Joyce Wasicuna, and other former employees of DOCFS.

Bev Flett and Ella McKay were not talking about 1988. They were talking about 1992. They were not "disgruntled former employees of DOCFS". They were competent, respected, senior employees. Their evidence demolished Isaac Beaulieu's assurances that any problems that existed in 1988 had been solved. They did away with Mr. Bakken's message that this inquest was hearing yesterday's news. The problems are current. They are at least as serious today as they were when Lester died.

DOCFS has had ten years to demonstrate that they can operate a competent child welfare agency. The problems described at this inquest convince me that they have fallen far short of the mark. More disturbing still, their initiative of 1991 (as a result of which the DOCFS Board has become totally politically controlled) shows that they seem determined to continue convincing themselves that they are doing a wonderful job while the DOTC communities suffer.

Isaac Beaulieu reported that at a June, 1992 meeting of aboriginal leaders, Chief Louis Stevenson asked rhetorically "why should we listen to the very people who have devastated our people and our culture?". I will comment further on in this report about the part that the Indian leadership has played, or has failed to play, in addressing the serious social problems on reserves, and I will leave the question

of who is responsible for devastating Indian people and their culture to sociologists, anthropologists and historians. However, leaving the rhetorical part of Chief Stevenson's question aside, the answer to his question is as follows: He must listen to the province in matters of child welfare because the province is ultimately responsible for the safety of Canadian children who live in Manitoba. Indian children are Canadian citizens. Indian children have the same rights to protection as other Canadian children. They are not the "property" of one ethnic or racial group any more than any Canadian child is "property"! The Child and Family Services Act recognizes aboriginal heritage. Culture is important, but as Dr. Charles Ferguson succinctly put it, in order for a person to appreciate her culture and traditions, that person has to first survive her childhood. The primary right of a child to a true childhood comes before racial, ethnic or religious considerations. The province has assigned responsibility for child welfare to the Director. The Director is responsible for the delegate agencies. At the present time one of the delegate agencies, DOCFS, is not doing its job. Children are not being adequately protected. One of the reasons has to do with its present organization. The province must intervene to correct this situation. If the situation is not corrected DOCFS' mandate must be withdrawn.

That is the answer to Chief Stevenson's question. Perhaps at some point the legal situation will change.

Perhaps national child welfare legislation will be passed. Perhaps an aboriginal government will assume responsibility for aboriginal child welfare. These things will become clear as the universe unfolds. As of September 1, 1992, the province is ultimately responsible for the welfare of all Canadian children resident in Manitoba - all of them.

I have concluded that a radical restructuring of DOCFS is required if DOCFS is to properly carry out its functions. I have also concluded that DOCFS is not able to restructure by itself and must be compelled to do so. Finally, I have concluded that it is the province's responsibility to force change in order to meet its obligations to the welfare of aboriginal children living in Manitoba. For these reasons I will be making recommendations for change at the conclusion of this chapter. Before I do that I will set out some of the history of DOCFS in order to explain how the agency came to its present sorry state.

Ernie Daniels testified that DOCFS was actually born at the Provincial Building in Brandon in 1979. There was tremendous dissatisfaction in the aboriginal community with children's aid societies in general, and Indian leaders took it upon themselves to design something for their communities. The chief architect was Dave Daniels, who was the Executive Director of DOTC for a number of years. Ernie Daniels was very much involved, as was Isaac Beaulieu. The vision that these people had for DOCFS was clear. Reserve communities would join together under the umbrella of the

Dakota Ojibway Tribal Council and operate services for their communities. The services would include policing, probation and child welfare. The tribal council concept would make it possible for small communities to fully participate, and at the same time, to do so in an efficient way.

Fundamental to the vision was the local child welfare committee. Each community would be able to participate in child welfare, a matter that vitally effected their community, through the operation of the committee. The committee would be composed of concerned people from the community, and would meet regularly to consider child welfare cases. Examples were given at the inquest of how these committees were to operate. Child welfare workers, and sometimes supervisors, would meet with the committee. Matters such as truancy problems, funding concerns, and the like would be discussed. Child welfare workers would ask the committee about specific families and their needs and resources, and generally there would be consensus reached by the end of the meeting.

The meetings would be beneficial to the members of the community, who were able to participate in this important way, and to the workers, who would gather valuable information to assist them in doing their jobs. But it was clear to the people who created DOCFS, and it was clear to DOCFS head office, that the community committee was to be an advisory body. It was the worker in consultation with the supervisor who made the final decision in child welfare

matters. For instance, a worker who was trying to decide whether a child should be apprehended or left in a home would be able to discuss the matter freely with the committee, obtain its advice and other useful information about the family and the community, but in the end the worker would have to decide in consultation with the supervisor whether to apprehend or not.

The evidence presented to this inquest convinces me that at least until the time of the Yellowquill Study in March 1989 (Appendix 4 of Exhibit 53(b) ) it was clear to the people at DOCFS head office in Brandon that although the local child welfare committee was a very important component of their child welfare structure, the workers made the final decision.

Ernie Daniels confirmed this. Morris Merrick gave this opinion (No. 44 of Exhibit 28 at page 25). That was Esther Seidl's opinion when she was Executive Director of DOCFS. It was also the very clear opinion of Vic Savino, the DOCFS Winnipeg lawyer. In fact, Professor Freda Steel, who arbitrated the Marion Glover and Dakota Ojibway Tribal Council labour dispute made this finding. Professor Steel says at page 19 of her adjudication (Exhibit 28).

> "There was some evidence of interference by the local Child Welfare Committee. While the members of this committee quite rightly have great concern for their children and wish to be involved in planning for their treatment, it is clear that DOCFS feels that the committee is advisory only."

So the purpose of the local child welfare committee, prior to the Yellowquill Study was clear to the people at DOCFS head office.

But it was not clear at the reserve level. I asked numerous witnesses, both Sandy Bay residents and DOCFS workers at Sandy Bay, and met with many different answers. Some were not sure, some thought that the committee made the final decision. There was extreme confusion about exactly what the role of the committee should be. The important point here is that the purpose of the committee was not clearly understood at the reserve level.

Certainly Cecil Desjarlais didn't know what it was. He thought that he had the right as a band councillor to not only sit on the committee, but play social worker as well. The other members of the committee were not able to do anything about it, not only because Cecil Desjarlais was a powerful local politician, but also because they didn't understand themselves what they were to be doing. (It must be remembered that DOCFS had been in existence for more than five years before Marion Glover came on the scene). There was a clear failure on the part of DOCFS to educate people in the communities they served about the role of the committee, and this contributed to many of the problems in this case.

The Yellowquill Study further muddied the waters. It recommended, among other things, that the local child

welfare committee should not be simply an advisory body, but should have the power to actually make the decisions. I will give my opinion later in this report that this is a very bad idea, and would only exacerbate the problems I will discuss concerning lack of training and education on the part of the workers, but at this point I will say only that the recommendation served to further confuse everybody at DOCFS about what the committee should or should not be doing. It gave some of the more extreme chiefs and councillors more ammunition in their insistence that the committees should have the final say.

Summing up this point, a constant theme running through all of the cases discussed at this inquest was the extreme fuzziness about the role of the local child welfare committee. The fuzziness tended to get worse rather than better in recent years.

I noted that the Yellowquill Study (appendix iv of Exhibit 53(b) ) suggests that the local child welfare committee should make decisions in the case of child welfare problems. In my opinion this would be a backward step, and would only intensify the problems noted in this report. For instance, a committee composed of lay people cannot be expected to know about treatment options off the reserve. Lay people cannot be expected to know social work theory, treatment theory and the like. Many of the problems evident in the cases discussed at this inquest came about because of lack of training on the part of DOCFS child care staff.

These problems would be magnified if the committee was expected to make the decisions as opposed to providing guidance and assistance.

For example, if a committee took the position, as it might, that all children from its reserve should be dealt with on the reserve, there would simply be a repeat of horrendous cases such as the case of Allison Desjarlais.

There will be cases where a child's best interests require that she be removed from the reserve. If a child is in danger on the reserve, the child must be placed elsewhere no matter what the political philosophy of the reserve residents may be.

Reaching for Solutions, a federal government study headed by Rix Rogers was referred to at this inquest. It is Exhibit 83. A New Justice for Indian Children, a paper prepared by the Child Protection Centre in 1987, was also referred to frequently at the inquest. It is Exhibit 68. Both of these publications describe cases in which children's best interests require that they be removed from their extended family, and from their community. Descriptions are given of extended families that have been dysfunctional for generations, and in which incest has thoroughly corrupted the family. In the extended family infested with incest described in Reaching for Solutions, and A New Justice for Indian Children, it would be seriously wrong to force the child to stay within that family. A professional social worker can ensure that this does not

happen, even if the decision has to be made over the objections of committee members.

If special treatment not available on the reserve is necessary for the child, the child is entitled to receive that treatment, even if it conflicts with the philosophy of reserve residents.

Simple notions, such as "all children should remain on the reserve", cannot be allowed to prevail over the much more important consideration that one must act in the best interests of children in each and every case.

I recommend that the committees do what they were originally intended to do, namely provide useful information to the child care worker, but at the end of the day, the child care worker, in consultation with her supervisor will make the decision. The decision must not be made by the committee, band councillors, or anyone else not trained in social work.

This would not lessen the importance of the local child welfare committee in any way. In fact, I believe that the committees should be strengthened. They should be given much better training, and committee members should be expected to participate in training sessions concerning child abuse and all aspects of child welfare. But the final decision in all cases must rest with the worker and supervisor.

DOCFS must clearly communicate this information to their staff and reserve residents. Chiefs and councillors

must accept that the committees are advisory only. I will be strongly recommending that DOCFS immediately develop a policy and procedures manual. The role of the committee must be clearly set out in the manual.

The other change I strongly recommend in relation to the committees is that band councillors should be ex officio members only. They must not be participating members. They must not be eligible to act as chairpersons of the committees, and above all they must not be eligible to be selected to sit on the DOCFS Board. I am convinced that having council members actively participate on the committees and on the DOCFS Board is one of the reasons why child care on the DOTC reserves is so poor.

The ex officio council member could still play a valuable role. The councillor could bring useful information to the committee, and take useful information back to the chief and council. But the councillor must not be a participating member. He would play a liaison role.

Vic Savino, DOCFS Winnipeg counsel, brought some very useful information to the inquest on this point. He described how he and others are working on a structure for an emerging aboriginal child welfare agency. They are designing it in a way that will prevent, or at least minimize, political interference. Their plans call for a prohibition on band council members sitting on the child welfare agency Board of Directors. Those Directors will be elected from the individual local child welfare committees.

Band council members will not be eligible for election. Mr. Savino recognized the destructive role that political interference has, and he is attempting to design a system that will stop it from occurring.

I became convinced early on at this inquest that these organizational changes were absolutely essential. I described this changed system to Isaac Beaulieu and asked Mr. Beaulieu for his comments. Even with his natural tendency to be non-committal and vague, he was in agreement with the concept. Morris Merrick was more candid and direct. He called this non-political system the "ideal" system, and an obvious improvement over the present politically clogged morass.

In summary, the local child welfare committee must be told that it is an advisory body. Everyone else within DOCFS, and on the DOTC reserves must be given this information. This must be written down in the policy and procedures manual. Band councillors must be ex officio committee members only. They must not be fully participating members. They must be ineligible to serve as chairpersons of the committee, and they must be ineligible to be elected to the DOCFS Board.

The next part of the DOCFS structure that is in urgent need of reform is the DOCFS Board.

Isaac Beaulieu testified that DOCFS has already taken the step of reinstating the DOCFS Board, or Regional Committee. The Board was originally intended to be composed

of representatives from each of the eight local child welfare committees. As I mentioned earlier, in approximately 1984 the Board was disbanded by the chiefs, and it was only when Esther Seidl became Executive Director of DOCFS that a Board was reinstituted. Esther Seidl believed that a Board was vital to give direction to DOCFS.

Instead of reinstituting a Board made up of representatives from the local child welfare committees, as was intended by the creators of DOCFS, the chiefs simply took on the Board function themselves. Isaac Beaulieu has described how this situation was entirely unsatisfactory. Instead of more local control, the exact opposite occurred. Decisions were made from the head office and not from the community. After the Yellowquill Report (Appendix 5 of Exhibit 53(b) ) was completed, DOCFS was forced to reinstitute a Board of sorts. However, in 1991, for reasons that I do not understand, it was decided that the DOCFS Board would be henceforth composed of representatives from the band councils instead of from the local child welfare committees. This was a very poor decision and made a bad situation even worse. What it effectively meant is that politics would control the bottom, top and middle of the organization. This 1991 decision, more than any other single piece of evidence demonstrates why the province must intervene and insist that this hopelessly gnarled structure be rebuilt.

The original idea, namely that the local child welfare committees would be made up of reserve residents concerned about the welfare of their children and that each committee would elect their own chairperson, and hence their own DOCFS Board representative, was the right idea. Even Isaac Beaulieu, who has bent over backwards to defend the chiefs, admits that he cannot defend the 1991 change, and that he disagrees with it.

I recommend that the DOCFS Board be made up of individuals elected by each local child welfare committee, as originally intended by Dave Daniels and the other architects of DOCFS.

At the child care personnel level, I will discuss in the following chapter the serious education and training gap that exists within DOCFS, particularly at the supervisor level. Dealing with that problem, in my opinion, is vitally important if the confusion problem is to be solved.

Finally, DOCFS does not have a current policy and procedures manual. Apparently when DOCFS was formed there was some type of rudimentary policy and procedures manual prepared, but the document was not produced at this inquest, and the evidence was to the effect that if a manual existed the child care workers and the local child welfare committees did not know about it. In fact, when the Yellowquill Study was done, and the people doing the study asked for the manual, a search had to be carried out to locate the document. It was evident to Tim Maloney and his

colleagues, the people who conducted the Yellowquill Study, that the document was a relic and was not being used.

Evidence was given to the inquest that it is standard practice for child caring agencies to have and make use of policy and procedures manuals. In the event of a question about lines of authority, or procedure to be used in a case, the first response is to consult the manual. The fact that DOCFS has none has no doubt contributed to many of their problems. I suggest that it is vital that a policy and procedures manual be developed, and I suggest that this task be undertaken immediately.

I have no confidence that a recommendation to DOCFS alone will have any effect.

The Hudson Report stressed the extreme importance of developing a policy and procedures manual. Dr. Hudson carefully explained why such a document was useful to the successful operation of a Child care agency. Specifically, Dr. Hudson recommended, at p. 24:

> "That a comprehensive review of the policy manual be undertaken with a view to changing any procedures or practices that are inconsistent with agency philosophy, program purpose or the needs of the DOCFS reserves, and that revisions to the manual clearly specify respective accountability for service elements with each program area."

That was in 1984. This is what Yellowquill (1988) had to say about DOCFS's response to that recommendation (at p.24):

> "The manual referred to in the 1984 review was drafted in 1981 and had long since fallen into disuse. During this review it could only be located at one of the bands and had not been referred to recently. Since new child welfare legislation was assented to in July of 1985 its applicability would be limited."

Yellowquill again explained to DOCFS why a manual is extremely important, and recommended in strong terms that DOCFS develop a manual.

Even when Isaac Beaulieu was shown policy and procedures manuals of another child care agency he insisted that perhaps the papers he had collected from his basement and other locations might in fact be a policy and procedures manual. He acknowledged that staff at DOCFS had no access to these papers. The Chairman of DOCFS did not know what a policy and procedures manual was!

I do not believe I am being overly cynical when I suggest that DOCFS cannot be counted on to develop a manual by itself. Therefore, I recommend that the Director assist DOCFS to develop a manual, and that the Director ensure that this is done within six months from the release of this report.

I believe that the development of a policy and procedures manual that clearly outlines the lines of authority within DOCFS will greatly assist DOCFS to resolve their organizational problems. The manual must describe the role and functioning of both the DOCFS Board and the local

child welfare committees. There will be many matters that DOCFS will have to address in addition to these central issues, but they have the Hudson Report, the Yellowquill Report, and the Director's review (Exhibit 53(b) ) to assist them.

This should have been done long ago. It must be done now.

I will be noting in this report the virtual absence of the Director of Child Welfare from the affairs of DOCFS. I will also be giving my opinion that because of the many problems that exist in this agency, it is absolutely necessary for the Director to become involved and stay involved until these problems are solved. I recommend that the Director actively work with DOCFS to resolve the confusion problem, that the Director monitor the situation, and that the Director ensure compliance.

When working towards the untangling of the current disorganization and confusion within DOCFS and assisting DOCFS to develop a policy and procedures manual, the Director must not be intimidated by claims that DOCFS is being forced to operate like a "typical children's aid society" or other similar excuses. Clear lines of authority are just as necessary for an aboriginal agency as for any other agency.

I realize very well that these recommendations will be resented very deeply by DOTC and DOCFS. Isaac Beaulieu has hinted many times in a polite but clear way that the agency

and tribal council must be allowed to take care of their own business, and their internal structure is none of the business of the court or of the province - in blunt terms, I should keep my big judicial nose out of it.

It is clear to me that DOCFS regards the present problems as a minor blip, and something that can be cleared up rather quickly. They have referred frequently to the observation made in the Aboriginal Justice Inquiry Report that aboriginal agencies are doing excellent work, and they should not be deterred by meddlers and minor scandals. It is clear that the Director takes a similar view. DOCFS believes that it has already solved its problems by its so-called "reorganization" (Exhibit 99(c) ), which consists essentially of shifting a few workers around and changing some job titles, and with the so-called "comprehensive review" described in Exhibit 99(b), which is simply a continuation of the status quo arrangement between DOCFS and the directorate (an arrangement that has brought thoughtful, dedicated people like Joyce Wasicuna, Bev Flett, and Ella McKay to despair). If the object is to avoid intervening at all costs they are right. If the ultimate goal is the protection of children they are dead wrong. Only immediate and drastic intervention can put things right.

The founders of DOCFS had a good idea. They were very unhappy with an imposed system that did not serve their needs. Although the view of history given by more than one witness at this inquest consisting of ignorant, uncaring

white social workers snatching children from reserves for no reason, and depositing them in abusive homes in the United States, more properly belongs to comic books than to history books, the fact is that aboriginal communities did not do well under the previous system. Dave Daniels, Isaac Beaulieu and other pioneers set out to correct this situation. They designed a system that would allow aboriginal communities to control their own child welfare system. Communities would participate at a grass roots level by means of the local child welfare committees. The agency would receive direction from a Board consisting of representatives from each of the committees. In the middle would be the workers, supervisors and other staff personnel who would be every bit as competent as their non-aboriginal counterparts, and just as able to concentrate on the paramount and fundamental goal of the agency, namely to protect children.

In the early years of DOCFS this was beginning to happen. The description given in the Aboriginal Justice Inquiry Report would quite accurately describe the direction DOCFS was heading in the first years of its operation. But things began to go wrong. The chiefs and councillors insisted on injecting politics into the system at all levels, and meddling in the daily operation at the agency, out of the misguided notion that this would result in more community control.

In fact, exactly the opposite has happened. Workers have to worry about so many other things that they are not able to properly do their jobs. Lines of authority have been completely mangled. Anarchy and confusion prevail. The vision has been lost. The province must not let protestations and cries of "paternalism" from Indian leaders who are responsible for this mess from deterring it from its duty to protect children. The province must intervene.

I have come to the conclusion that intervention by the province must include legislation. Legislation must obviously apply to all aboriginal child caring agencies in Manitoba and not only to DOCFS. I will explain why I have come to this conclusion.

DOCFS is not the only aboriginal child welfare agency struggling with these problems. It is clear from the evidence that came forward at this inquest that the same problems are faced by the other aboriginal child welfare agencies in Manitoba. I realize that the aboriginal leadership generally advocates for national child welfare legislation. That may or may not be a step forward. I will be making no recommendation for or against such a change, as that is a purely political matter, and far beyond the scope of a hearing of this type. However, whether federal, provincial, or Indian legislation ultimately applies, there must be rules, and there must be accountability. At present, provincial law applies to child welfare, regardless of the race or origin of the child. The province must be

prepared to carry out its responsibility to Indian children, and the Indian leadership must accept this authority unless and until the legal status quo is altered.

I am not attempting to give some type of a constitutional ruling when I make my recommendation for legislation. I am aware that the constitutional question of services for Indians on and off reserves is exceedingly complex, and that at the present time the entire constitutional structure is being debated actively at the political level. However, the situation that now exists, with the province wanting to play as small a role as possible in reserve child welfare matters, and the Indian leadership recognizing minimal involvement only by the province, and the federal government funding only, is intolerable. I will give my opinion in this report that this situation - child welfare on Indian reserves being regarded as some type of "no man's land", has contributed in no small part to the problems discussed at this inquest. Sitting back and waiting to see what will happen, which is the position that the provincial government has taken since this was first identified as a problem many years ago, is an abdication of responsibility.

I am also aware when making this recommendation for legislation that the recommendation is for a major change in government policy - a policy that has been passed on from one government to the next for years. However, the age of a policy is no measure of its quality. This policy, or more

accurately, this non-policy, is a bad one, and a disgrace to the governments that have allowed it to continue.

Finally, I am aware that DOCFS and the other aboriginal agencies will resent any type of "intrusion" and particularly so if it is in the form of legislation. However, I do not believe there is any other way of removing politics from aboriginal child welfare agency structures. The DOCFS argument that legislation that applies only to aboriginal agencies and not to non-aboriginal agencies is racist is clearly specious. Aboriginal agencies have local child welfare committees, and non-aboriginal agencies do not have them. This is because aboriginal communities wanted to have a structure that suited their traditions and way of life. Their agency Boards are different for the same reason. The specific reference in the Child and Family Services Act to aboriginal people was included at the request of the aboriginal communities. For DOCFS to argue that amendments to the Act that apply only to aboriginal agencies is "racist" or unacceptable because they do not apply to non-aboriginal agencies with different structures is an argument that should not be taken seriously.

It is for all of these reasons that I have come to the conclusion that legislation is absolutely necessary if the confusion problem is to be solved.

I recommend that The Child and Family Services Act be amended to require that the changes that I have recommended

for DOCFS apply to all aboriginal child care agencies, namely:

1. Chiefs and councillors must be prohibited from sitting as participating members on local child welfare committees, and henceforth they must play a liaison role only.

2. Chiefs and band councillors must be prohibited from sitting on child welfare agency Boards.

3. Child welfare agencies must be required to have policy and procedure manuals that are judged to be acceptable to the Director.

I am aware when I make recommendations for legislation depoliticizing aboriginal child welfare agencies that it would have been preferable if I had been able to make a recommendation to the Indian leadership for reorganization, with no recommendation to the government for compulsory legislation. However, it is very clear to me that these recommendations would not be followed. In the case of DOCFS, recommendations have been made on a number of occasions and the DOTC leadership has simply ignored the recommendations. I am convinced that unless legislation is passed insisting that the aboriginal child welfare agencies depoliticize their organizational structure, no changes will occur. There may be cosmetic "reorganizations", but band councils will continue to insist on meddling in the affairs of child welfare agencies. Chiefs will refuse to accept what they call "outside interference".

I am also aware when making this recommendation for legislation that the provincial government has been very reluctant to legislate in the area of aboriginal child welfare. I will comment further on this reluctance on the part of the government in my chapter entitled "Absence of Director". Evidence came forward at this hearing about this historical reluctance on the part of the provincial government mainly in the form of semi-political speeches from male aboriginal witnesses about the "60's scoop". This "history" consisted mainly of blaming "white children's aid societies", and "white social workers" for destroying Indian communities by randomly apprehending children and shipping them off to the United States.

A more careful look at the material presented at the inquest tells a different story, and indeed the more thoughtful witnesses touched on this. It goes as follows: the provincial government took the position that matters having to do with Indians, including Indian child welfare, were primarily the responsibility of the federal government. The federal government took the position that child welfare, including Indian child welfare, was primarily the responsibility of the provincial government. The Indian leadership took the position that it did not want the provincial government to legislate in the area of Indian child welfare, and it consistently advocated for national child welfare legislation.

This "standoff" resulted in the "life and death" policy on the part of the provincial government discussed at the inquest. Under this policy, children's aid societies, or the provincial Department of Family Services (in areas not served by children's aid societies) would intervene on an Indian reserve only in cases of life and death. This state of affairs was unsatisfactory to everyone concerned. It resulted in two completely different standards of child care; one for non-aboriginal children, and one for aboriginal children on reserves. Aboriginal children would be left in situations that would be deemed unacceptable for non-aboriginal children. Graeme Garson (then Judge Garson) strongly criticized the "life and death" policy (AJI Report, p. 521 - Ex. 73 (f)). So did Associate Chief Judge Ed Kimelman in the Kimelman Report (Exhibit 73(g) ). Everyone agreed that change was necessary. There was almost universal agreement that the aboriginal community must be empowered to deal with aboriginal child welfare matter.

However, instead of an orderly transition done in stages, with the Director actively involved to ensure that the new agencies were properly equipped, trained and ready to assume responsibility for child welfare, responsibility was turned over to the new agencies almost overnight. To make matters even worse the Director did not ensure that agency personnel had the proper educational backgrounds and training. In too many cases the Director turned the vitally important responsibility for child welfare over to people

whose main qualification for the job was their aboriginal background, and their "life experience". Following the transfer of responsibility the Director maintained a "hands-off" policy and would intervene only when scandals arose.

What this effectively means is that because the reserves served by the aboriginal agencies remain problem-ridden and the aboriginal agencies themselves are riddled with all of the deficiencies described at this inquest, the "life and death" policy of the sixties is continuing on to this day in the form of the government's "hand-off" policy. The result is the same - a standard of care for aboriginal children on reserves that is far lower than the standard that exists for non-reserve children.

The provincial government maintains its stance that Indian child welfare is really a matter for the federal government. The federal government insists that child welfare, including child welfare for Indian people, belongs to the province. The male Indian leaders are not only by and large uninterested in the horrific social problems that are paralyzing their communities, but they are, in too many cases, part of the problem themselves. In any event, they insist on refusing to submit to provincial legislation so that their political goals will not be compromised.

All three actors in this sad equation have shown themselves to be quite prepared to grind up a few generations of Indian children rather than resolve this dispute. This "triple whammy" of calculated neglect has

helped to produce the parents of the neglected and abused children discussed at this inquest. Those tortured lives tear at the heart and shame us all.

This description is a simplification as well. But compared to the "history" of social workers and children's aid societies "devastating" Indian communities that was trotted out time and time again at this inquest, it is much closer to the truth.

It is my opinion that it is incumbent on the provincial government to legislate in this area to fill this vacuum.

It is also abundantly clear to me that an Indian leadership that has been quite willing to compromise the safety and well-being of children on a matter of principle will simply ignore recommendations to depoliticize agencies. There must be intervention. Intervention is not "racist" or "paternalistic", or any of those words meant to stop uncertain people dead in their tracks. It is the only responsible course of action that can be taken.

**B. EDUCATION**

There is another problem faced by DOCFS that is at least as serious as the confusion problem. It is the problem of the education gap, and until it is addressed, DOCFS will remain a third rate agency.

Both at the child care worker level, at the supervisor level, as well as at the Executive Director level, DOCFS is seriously deficient. It is my opinion that the lack of education and training of the workers has contributed, and is contributing to an inability to properly protect children within its jurisdiction. As a major recommendation from this inquest will relate to training and education of DOCFS workers and supervisors, I will set out below some of the evidence that has come forward on this point before making my recommendations.

When this inquest began in October, 1991, one of the pleas from some of the witnesses, and in particular from Elaine Scott, Esther Seidl, and Marion Glover, was that this inquest inquire into the serious lack of training of the workers. Elaine Scott volunteered the information that there were a lot more kids like Lester Desjarlais out there, and that some of the workers were simply not equipped by their training to handle such difficult cases. Specifically, Ms. Scott referred to the fact that New Careers training is the norm, and that that type of training is simply not sufficient to enable a worker to handle difficult cases like the case of Lester Desjarlais.

Esther Seidl and Marion Glover expressed similar views. They noted that while the norm in non-aboriginal child caring agencies is to hire university graduates, that is not the norm at DOCFS. Child caring agencies within Canada look for a person with a Bachelor of Social Work degree and related experience for child care workers' positions. At the supervisor level, the norm is either a Masters of Social Work degree with considerable experience as a child care worker, or at the very least a Bachelor of Social Work degree, with a number of years of related experience as a child care worker.

Bruce Fraser, the former Executive Director of Child and Family Services of Western Manitoba, described to the inquest one example of a supervisor with his agency who had only a community college diploma. This person was a senior, respected worker with thirty years of child care experience, who had upgraded her qualifications by attending numerous seminars and workshops. She had also applied unsuccessfully for a supervisors position in past years. She persisted, and finally attained the supervisor's position. The point here is that this person was an exception to the rule. Only because of exceptional experience, and the esteem in which she was held by her colleagues, did she become a supervisor. Normally a candidate would be expected to have at least a Bachelor of Social Work degree with  years of child care experience before being considered eligible for the crucial position of supervisor.

This is not the case at DOCFS. Not only are the child care workers under educated, the supervisors are often simply child care workers who have stayed with the agency for a time, but who have not upgraded their qualifications.

Let me put forward some cold, hard facts here to illustrate the seriousness of the problem. DOCFS does not employ one person with a Masters of Social Work degree. This is a child care agency with a budget in the millions of dollars. It appears that DOCFS employs only three people with Bachelor of Social Work degrees. Most of the child care workers and supervisors have training that consists mainly of their New Careers training. DOCFS workers at the field level and at the supervisor level are under-educated.

Making matters worse, there appears to be a serious turnover problem. Delores Roulette, a child care worker at Sandy Bay, commented that from 1984 when she started employment with DOCFS, until 1987 they had more than six supervisors for their reserve. People would come and go at the child care worker level, and at the supervisor level. There would be no continuity. Supervisors, who were both undertrained and new to the reserve would not be able to provide proper supervision. In fact, one of the problems in this case was the fact that when Marion Glover became supervisor for Sandy Bay, the Sandy Bay child care workers had simply had no supervisor or no effective supervision for so long that they were not used to working under

supervision. They were taking their direction not from a supervisor, but from local politicians on the reserve.

It should be noted that the position of supervisor is critical to a child care agency. Bruce Fraser testified that supervision from an experienced and qualified supervisor is vital, and in fact the less qualified and less experienced the child care workers, the more important supervision by a good supervisor becomes. Mr. Fraser said that the combination of inexperienced child care workers and supervisors in an area of difficult socio-economic problems, such as Sandy Bay, is a "recipe for disaster".

A few examples might be of assistance. Delores Roulette was a child care worker at Sandy Bay from 1984 to early 1992. She has now taken a related position with DOCFS in Brandon. In 1984, when she was hired by DOCFS, she had no child care training either at the community college level or at the university level. She was simply hired as a child care worker and she was expected to do her job. It was not until 1987 that she began her New Careers training. That training consists of alternating two week educational sessions with six weeks work sessions. The total training time is two years, at the end of which time a worker gets a certificate proving that they took the course.

New Careers training is not criticized in this report. It is obviously a good thing, and it is helpful to people. I have examined the New Careers material (Exhibit 74) and the creators of the package should be commended. But it is

not the equivalent of a Bachelor of Social Work degree, or even a community college diploma course. It is mainly designed to help people who have been disadvantaged enter the work force. One of its main goals is to build self-esteem in the individual. A New Careers course could be used as a first step towards community college or university. It is a beginning only. It does not complete an education.

That is not what happened in the case of Delores Roulette. Except for occasional workshops, which occurred a few times a year, her total child care education consisted of her New Careers training. No incentives were offered by DOCFS to have her upgrade her education by sponsoring her through university or community college. It appears that her level of pay would be the same whether she had a university degree or New Careers training. Most surprising of all, Delores Roulette did not seem to believe that proper training would assist her to do her job, and neither did DOCFS. Ms. Roulette believed that because she was a mother, and she had clerk-typist experience, she was qualified to be a child care worker.

The case of Ron Mousseau is similar. Until his suspension, he was the supervisor at Sandy Bay. Mr. Mousseau upgraded his education through continuing education at the University of Manitoba, (I assumed this to be a part of the New Careers Training at the time), and he took workshops as and when they became available. Mr. Mousseau

does not feel that a university degree in social work would assist him in his work. As with all of the DOCFS workers questioned on this matter, he gives the example of a university graduate fresh out of school coming to a reserve and knowing nothing about conditions on the reserve, as the reason why social work training through the university is of little value. He believes that "life experience" is what is required for child care work, and formal training in social work is unnecessary. He said "book smarts" were not important, but "people smarts" were. This reverence of "life experience", and this sneering attitude towards formal education was typical of the attitudes of DOCFS workers who testified at this inquest. If the "life experience" argument is taken to its logical extreme, the older a person gets, and the more troubles he has in his life, the more qualified he is to do any job, no matter how complex, in spite of a total lack of formal education. The DOCFS witnesses generally did not appear to see the weakness of their argument on this subject. "Life experience" and the worthlessness of formal education appeared to be preachings of a strange new gospel.

Bill Richard was even more adamant about the lack of value of education. Mr. Richard is an older man with less than an elementary school education. It is not clear whether he has even satisfactorily completed his New Careers training requirements. He scoffed at the mere mention of formal training.

This view on the part of DOCFS workers, and indeed it is a view shared by the Executive Director of DOCFS, is radically different from the prevailing view in Canada, namely that child care workers are professionals in the same way that teachers, doctors or lawyers are professionals. It is considered desirable across Canada to have a Bachelor of Social Work at the child care worker level, and a Masters of Social Work at the supervisor's level. Of course it is considered desirable to have experience as well. There appears to be a recognition across Canada that a person is not qualified to deal with complicated child protection matters, such as cases of sexual abuse, and work with damaged children, merely by virtue of being a parent, or having "life experience". The view of DOCFS differs markedly from the prevailing view about child care.

Another theme, even more nebulous than the over reliance on "life experience" also emerged from the testimony of DOCFS personnel. It was the almost mystical belief that simply by virtue of being aboriginal a person somehow became competent to work with aboriginal children. I mentioned earlier in this report how DOCFS seemed to believe that anybody could become a proper foster parent for an aboriginal child as long as that person was aboriginal. Training and basic competence were far down on the list, and aboriginal heritage was at the top.

The same kind of fuzzy thinking was evident in the case of training and education of child care workers. Over and

over again workers stressed their aboriginal heritage as proof of their competence as child care workers. Even with the most complex child care issues an aboriginal heritage (and "life experience") were considered to be more important than education, training and related child care experience.

This is nonsense! While it is certainly desirable for a child care worker working with aboriginal children to be aboriginal, the more important part of the equation by far is expertise, that is, a proper educational background and related child care experience. Given a choice between an aboriginal person without the proper educational background and no related child care experience, and a non-aboriginal person with the necessary expertise, DOCFS has chosen the former.

This bad choice has contributed to the problems discussed at this inquest. The choice was made at the expense of children. There is no magic to a worker simply being aboriginal any more than there is in being non-aboriginal and working with non-aboriginal children. The requirement for an aboriginal child who is at risk, for a properly educated and experienced child welfare worker is every bit as great as it is for any other child who is at risk. It is true that for many good reasons it is desirable for child care workers who work with aboriginal children to be aboriginal themselves. But they must be aboriginal people with expertise. DOCFS has been too concerned about a

worker's colour, and not concerned enough about her education and training.

There are examples that arose in this case that demonstrate this need. Elizabeth McLeod of the Brandon Mental Health Centre discussed the procedure used at BMHC in the case of children admitted either as compulsory or non-compulsory patients. As described at page 30, where a child who was admitted to BMHC was a ward of a child care agency, (not an unusual occurrence), the child care worker would be included in the diagnostic meeting held to plan for the child. These meetings would include presentations by the nursing staff, the medical doctor, the psychologist, and the social worker. Elizabeth McLeod said that only a properly educated worker could possibly understand what was being talked about at these meetings. She then made a very telling remark. She said that she was never sure whether or not Bill Richard was a worker with DOCFS, or a volunteer. As I interpret this, it was clear to Ms. McLeod, and presumably to her colleagues as well, that Mr. Richard was not in the same category as other workers. Mr. Richard would not be able to fully participate at the diagnostic meetings, because of his very limited education. The child concerned would not be properly represented by the Child care agency. This example stands out in my mind as a clear illustration of the need for well trained social workers, and their absence at DOCFS.

I will offer another example of the seriousness of the educational gap at DOCFS. When I heard this example my first reaction was to be diverted by its humorous aspect, but when I remembered that the safety and well-being of children depended on this worker it dawned on me that this was not funny at all. It was an example given by Marion Glover. It happened when she was employed as a DOCFS supervisor. She asked one of the child care workers under her supervision to do a "family profile" on a Sandy Bay family. This involves a meeting with the family involved and a written report about the family. Professional child care workers are familiar with the term and the procedure involved in obtaining a family profile. The child care worker assigned the task of doing this family profile had New Careers training that was obtained after an incomplete high school education (a typical DOCFS child care worker's background). He left to do the job and came back with what he thought a family profile must be. It was a photograph of the family! He had borrowed a camera and taken the picture of the family, and this was his idea of a "family profile". This example speaks for itself and needs no further description. The example is cited to make a point, and not to embarrass unnecessarily.

It is one of the ironies presented by this inquest that a person hired as a supervisor by DOCFS, and a person that proved herself to be head and shoulders above the other DOCFS workers at Sandy Bay, was herself unqualified to be

considered for the position of child care worker, much less as a supervisor, by Child and Family Services of Western Manitoba. Bruce Fraser testified that he fired Marion Glover because she had lied about her qualifications when she applied for the job of child care worker with his agency. Specifically, she had told Mr. Fraser that she had a complete grade twelve and a Bachelor of Arts degree, when in fact she had neither. But Mr. Fraser also said that if Marion Glover had not lied about her qualifications, she would not have been hired as a child care worker, because she did not have the necessary qualifications. She may have been eligible for a position as an aid or assistant, and if she upgraded her education she could have worked towards a child care position over time. But she simply did not have what it took to be a professional child care worker, much less to be a supervisor.

She was snapped up by DOCFS, and within three months she had become a supervisor. This says a great deal.

I realize that comments about under-qualified personnel will be embarrassing and hurtful to the people referred to, and particularly so because I am naming individuals. I apologize for this. But I simply do not know of any other way to make my point. It was clear to me when listening to DOCFS workers that many of them were decent, capable people who were dedicated to protecting children, and working for the betterment of their communities. Delores Roulette and Sandra Beaulieu stand out in my mind as examples. Both

people are obviously intelligent, caring women who have a profound understanding of their community, and a commitment to their community. I do not want my comments to be taken as criticism of these people. In fact, Sandra Beaulieu has returned to university, and in my opinion she could be an excellent candidate after graduation to play an important role in child welfare at Sandy Bay.

Similarly, Isaac Beaulieu is a man to be admired. He acquired his education at a time when there were even more obstacles standing in the way of aboriginal people then there are today. He has been involved in aboriginal child care and education initiatives from an early date. Although Mr. Beaulieu insisted on using entire inquest hearing days to list his personal accomplishments and give unrelated opinions rather than addressing the issues candidly, and while he is criticized by some of the witnesses at this inquest as a person who is on many task forces and who has held prestigious positions yet is not there when needed (and indeed Mr. Beaulieu must accept a good portion of the blame for many of the problems outlined in this report) he is still a man to be respected. Ernie Daniels is in this category as well. In spite of his rough edges, he is a leader. He is committed to advancing the cause of aboriginal people, and although he made many mistakes along the way, he acted out of this dedication. There are other people criticized in this report who also stand out in this way.

I recognize this, and in fact, coming from a background which in comparison to the background of most of these aboriginal people would be considered privileged, I am in awe of what they have accomplished, and the problems they have overcome. It is painful to have to strongly criticize people who have had to contend with problems most of us will never even know, and who have surmounted many huge obstacles. However, as I have become convinced by the evidence tendered at this inquest that children are not being protected by DOCFS I will risk offending people in order to make my point. As a result, this report is not couched in flattering terms, nor is it based on an unwritten premise that all aboriginal people are primarily victims, and consequently that different standards are to be applied to aboriginal people than to others.

It is my opinion that child care is just as important to a community as education or health care. In the same way that it is recognized that teachers in aboriginal communities must be as qualified and experienced as teachers in a non-aboriginal community, and that doctors and nurses in an aboriginal community must be as qualified and experienced as doctors and nurses in a non-aboriginal community, it must be recognized that child care workers in aboriginal communities must be just as qualified and experienced as their counterparts in non-aboriginal communities.

Put another way, aboriginal communities have just as much of a right to expect quality child care as other communities. Children living on reserves are entitled to expect the same standard of care as other children. They are entitled to protection by a qualified, professional child care worker who will not let them down.

When the province allows an inadequately trained child care worker to work for an aboriginal child welfare agency, it is doing so at the expense of children. The well known quote of Mr. Justice Samuel Freedman that "One more chance for the parent means one less chance for the child." comes to mind. That concise sentence says many things. For my purposes here, it points to the inescapable fact that one can only give incompetent parents "another chance" at the expense of the child. Similarly, one can only excuse inadequacy in a child care worker by doing so at the expense of the children residing in that worker's area. Unless the provincial government is prepared to publicly state that aboriginal children are not entitled to as high a standard of care and protection as non-aboriginal children, the provincial government must see to it that child care workers are properly educated and trained.

It is my opinion that many of the other problems within DOCFS that came to light at this inquest are directly attributable to the lack of education and training of DOCFS workers at the field level and at the supervisor and Executive Director level.

I will state an assumption at this point. I do assume that a child care worker, and a supervisor working for a child care agency, is a professional in the same sense as a school teacher, doctor, or lawyer is a professional. I assume that a person with no formal training in social work, no matter how capable or motivated, will be at a disadvantage when dealing with complicated child care matters as compared to a properly educated person. I also assume that aboriginal children are entitled to the same standard of care as non-aboriginal children. If any of these assumptions are incorrect, the opinion I give in this report that DOCFS workers are under educated at the field level, and particularly at the supervisor's level, in comparison to non-aboriginal agency workers, can be disregarded. If my assumptions are correct, and if my findings that DOCFS workers are not properly educated or trained are valid, then it behooves the government and DOCFS to make changes.

I also recognize that there is no magic in a university degree. There are reasons why many of the DOCFS workers immediately thought of a person with a university degree as a graduate fresh out of school hopelessly lost on a reserve, or a person who could not find employment elsewhere. That is the type of person that very often found employment on a reserve. Witnesses testified that in the past, too many white people with university degrees employed on reserves have disappointed reserve residents.

I maintain, though, that a university education is a necessary step in becoming a professional. Many parts of that education may initially seem to have little or no practical application, but the experience as a whole is absolutely necessary in order to enter a profession. The education, plus experience, combines to form expertise.

There are no shortcuts in this process. One cannot simply winnow out the unnecessary parts of an education, and gather in the practical parts. That is not how it works. A true education cannot be acquired in two week chunks, or by "Coles Notes" types of condensed courses. It is not something that can be given to a person. There is work and commitment involved.

I also recognize that there are deficiencies in all university programs. In this case more than one witness, including Dr. Charles Ferguson, pointed to what they view as very serious deficiencies at the University of Manitoba School of Social Work in the field of child abuse education. This is a problem that must receive attention, and in fact at page 205 I will be recommending to the government that this be explored with the School of Social Work, because of the criticisms from these knowledgeable people. But this is not a reason to stay away from university.

I am not the first to note the lack of education and training among child care personnel with DOCFS. In the Hudson report there is discussion about the same problems relating to education that I am describing.

The discussion is friendly and inoffensive, but it is particularly relevant to this inquest, because the problems it describes, of the paucity of professional social workers within DOCFS, the lack of training for workers, and the turnover problem, are the same today as when the agency was in its infancy eight years ago. There seems to have been no improvement.

The discussion and recommendations pertaining to staff development and training are found in the Hudson Report from pages 140 - 146. I will not repeat the discussion here. The problems were outlined, and Dr Hudson made very useful recommendations. The intent was very clearly to upgrade the qualifications of DOCFS personnel, and in time bring the qualifications of DOCFS workers up to the Canadian norm. That has not been accomplished. The evidence given by DOCFS personnel convinces me that DOCFS did not make even a reasonable effort to carry out these recommendations. The education and training gap was a huge problem within DOCFS in 1984, and it remains a huge problem today, to the detriment of the children DOCFS is expected to serve.

I did not allow discussion about "resources" at this inquest. I recognize that resources, and the lack thereof, is a huge issue for all child care agencies, aboriginal and non-aboriginal. Jim Bakken did testify that the present funding arrangement contemplates the hiring by DOCFS of professionally trained social workers. That is, DOCFS is given enough money to hire professionally trained people.

Other agencies manage to hire qualified people. The excuse of "lack of resources" for not employing qualified people is not valid.

I have noted an unsettling theme running through the discussion in some of the reports concerning DOCFS when they discuss training and education - a subtle form of racism. The unwritten premise of these reports, most notably the Yellowquill Report, seems to be an assumption that aboriginal people will not be able to become educated in the same way as non-aboriginal people; that it is somehow acceptable for aboriginal people to become child care workers with grossly deficient educational backgrounds, although this would be completely unacceptable for child caring agencies operating in non-aboriginal communities.

This type of excuse making may be well intentioned, but it is a type of racism, albeit friendly racism. There are certainly obstacles that stand in the way of many aboriginal people that do not confront many non-aboriginal people. But evidence was given that aboriginal people are graduating as teachers, nurses, lawyers and other professionals in increasing numbers. I am convinced by the evidence that there is just as much need for aboriginal professionals in the field of social work, as in any other field (perhaps more). Well intentioned non-aboriginal people who attempt to overlook this huge educational gap on the part of aboriginal people are doing aboriginal people no favours.

Similarly, a child care agency that scorns university training, and pretends that it does not need professional social workers, is doing the children it is mandated to protect no favours. It is placing those children at risk.

I recognize that the solution to the education problem is not easy. Isaac Beaulieu has given evidence about how difficult it is to attract aboriginal people with university degrees to the field of child care. Bruce Fraser noted that the child care field generally is considered by social workers to be the most difficult and unrewarding area of social work. It is obviously desirable to have aboriginal people working at the agency. It is also desirable to have people from the home communities work with the agency. However, the stark and simple truth is that DOCFS does not have enough people with expertise. I am going to be recommending that DOCFS and the Director develop a strategy to address this problem. The goal must be to attract more qualified people, especially at the supervisor level, to DOCFS. Aboriginal people should obviously be preferred for positions. But they must be aboriginal people with expertise.

Let me be clear. I am not recommending that all current DOCFS staff be fired and that DOCFS replace them with university trained people. If the agency is to continue to exist this is obviously not practical or realistic. Solving the problem must obviously not be done in a brutal fashion, with no regard for the people presently

working at DOCFS, many of whom are excellent people dedicated to child care, and dedicated to improving the lives of aboriginal people.

Solutions might include the sponsoring of deserving staff through university. For instance, Bev Flett and Ella McKay both stand out as outstanding advocates for children. They have extensive experience with DOCFS, and in the case of Ella McKay, with the Children's Aid Society before that. Perhaps the School of Social Work could design a shortened university program for people like this, who because of their extensive experience do not require much of the introductory material that is necessary for young people graduating from high school. Perhaps the School of Social Work could include components dealing with the aboriginal aspects of child welfare as well. In this way excellent people, such as Bev Flett and Ella McKay might be given the benefit of university social work training in a practical way.

Similarly, it may be necessary to develop strategies to actively recruit aboriginal people with social work degrees to come to the agency. These people exist. Wayne Govereau stands out as an example of the type of person that the agency should go after.

It may be possible to develop some type of sponsorship program, similar to the programs employed by the armed forces. Aboriginal high school graduates, or current DOCFS employees, could be sponsored through university with the

promise that they would return to the agency for a guaranteed minimum term.

DOCFS should not be quite as color conscious as they have been in the past. Tim Maloney stands out as a non-aboriginal person who served DOCFS very well in the past. DOCFS should not allow the understandable preference for aboriginal employees to prevent them from hiring the best people they can find, particularly in the next few years, until DOCFS can find more aboriginal people with the necessary expertise. They should hire the best people possible, including non-aboriginal people.

I am also not suggesting that all DOCFS child care personnel must immediately have university degrees. That is not realistic or necessarily desirable. But there must be a better mix. For instance, as an interim step at Sandy Bay, at least one of the workers should be a professionally trained person, and the other child care workers should have improved mandatory training. A worker like Bill Richard, who is a decent and concerned person, could become an assistant or aid to the child care staff, but he should not have all of the duties and responsibilities of a child care worker. The supervisor must be a professionally trained person with child care experience.

Much work will have to be done by DOCFS and the Director in order to overcome the educational gap. The fact that the educational gap now is just as serious a problem as it was when the agency was in its infancy is proof positive

that the Director must intervene and ensure that solutions are found. Aboriginal children and families must not be condemned to inferior service, and the educational gap must be eliminated.

I recommend that DOCFS, with assistance and direction from the Director develop strategies to solve the education gap.

I recommend that the Director monitor progress and ensure that DOCFS upgrades qualifications to the provincial norm.

I recommend that, as an interim step, at the reserve level at least one child care worker be professionally trained.

I recommend that workers with a specialty in child abuse investigations, such as protection workers, child abuse workers and co-ordinators must have specialized training in child abuse at the university level.

I recommend that at the supervisor level there be a minimum requirement of a Bachelor of Social Work degree or equivalent, and child care experience.

I recommend that the training of all non-university trained child care personnel be upgraded through an enhancement of the New Careers Program, mandatory child care workshops, and other programs deemed suitable by the Director.

I recommend that training be made available for members of local child welfare committees, and that the training be

mandatory. The training package must be approved by the Director.

I recommend that the Director add other components that he or she deems appropriate, and that the Director monitor all progress and enforce compliance.

I recommend that the Director meet with the University of Manitoba School of Social Work authorities to discuss the deficiencies in the child abuse area of social work education mentioned by witnesses at this inquest, including Dr. Charles Ferguson. I recommend that the Child Protection Centre be asked to participate in these discussions.

I recommend that the Director initiate discussions with the University of Manitoba School of Social Work to develop strategies to attract more aboriginal candidates to the School of Social Work, as well as to discuss possible inclusion of aboriginal child welfare components in the social work curriculum. I recommend that the task force I will discuss in the chapter of this report entitled "Social Problems on Sandy Bay and Denial" be asked to participate in these discussions.

There are other education and training ideas as well that can be explored. Joint sessions with other child caring agencies are one idea.

Bruce Fraser testified that in the years after the creation of DOCFS, there was friction between DOCFS and his agency, and very little co-operation between the two agencies. Although the "feuding" has stopped, it appears

from the evidence that there is a minimum of contact between the two agencies at this time, and although the offices of the two agencies are located in the same small city, the agencies have little to do with one another. It is my impression that they have contact only where they must.

It should be noted that Child and Family Services of Western Manitoba does deal with aboriginal families. Mr. Fraser estimated that at the time he left the agency (December, 1991) there were approximately sixty aboriginal families receiving services from his agency. Mr. Fraser also noted that although there have been aboriginal staff members at Child and Family Services of Western Manitoba in past years, he believed that there were none at this time.

The relationship between Child and Family Services of Western Manitoba and DOCFS can be contrasted with the relationship between DOTC Police and the City of Brandon Police. Deputy Chief Warren Fontaine, and Cst. Al Miller, of the DOTC Police described the present relationship between their force and the City of Brandon Police force, as well as the RCMP. Joint training sessions are held between the organizations. The goal is to learn from each other, and according to these men, the goal is being achieved. The City of Brandon Police and the RCMP are learning about policing on reserves, and about aboriginal matters. This will undoubtedly be of assistance to the City of Brandon Police and the RCMP, as both forces are required to deal with aboriginal people. At the same time, the DOTC Police,

a smaller force, is able to keep abreast of current developments in policing, and can learn about urban policing. The joint training sessions, and the good relationship that apparently exists among the forces, diminishes no one. It does not take away in the least from the autonomy of DOTC Police and appears to be appreciated by the police who participate.

I do not believe that it would be naive to suggest that Child and Family Services of Western Manitoba (and other non-aboriginal agencies), and DOCFS can look at the police relationships described above with a view to doing something similar. It makes no sense to have two agencies side by side, working with similar families with the rather anaemic relationship that seems to exist today. Yesterday's hurt feelings and today's egos should not be allowed to stand in the way of an improved relationship that could benefit both agencies and the children they are to serve.

This is the end of the chapter dealing with the education gap at DOCFS. I have made recommendations designed to first narrow this gap and ultimately eliminate it. The recommendations will only work if both the directorate and DOCFS cooperate closely on their implementation. I do wish to be understood on this point. In my opinion, the education gap is a very serious problem that must be solved. If DOCFS fails to work as hard as possible towards the elimination of the education gap, it is my recommendation that their mandate must be withdrawn.

As a final point on the education issue, it is clear from the evidence that the "educational gap" in this case is not confined to DOCFS. It is a problem experienced by all of the aboriginal child welfare agencies in this province. Mr. Bakken outlined the ongoing discussions within the directorate about the possible mandatory certification of child care workers. That is, child care agencies, aboriginal and non-aboriginal, would have to prove to the province that people hired as child care workers met certain criteria established by the province before they could be employed in that capacity by an agency. It is my opinion that the problems discussed in this report provide conclusive proof that such a system is necessary. It does not mean that the agencies would not have a voice in deciding what the certification standards were to be, but the province would ultimately decide on the standards, and it would be a requirement that all agencies meet those standards.

I am convinced that certification is just as important, and perhaps even more important, in the case of supervisors employed by agencies. Mr. Bakken acknowledges that the directorate has only recently begun to seriously look at this vitally important position. It became clear to me at this inquest that the position of supervisor is vitally important to an agency, and particularly so where the workers reporting to the supervisor are not as well qualified as they should be.

If the province is to move to certification it becomes obvious that the province must offer training to upgrade the educational levels of personnel to meet the child care worker certification standards, and to meet the supervisor certification standards. People who do not meet the standards should be given a reasonable amount of time to upgrade their qualifications, and the province should make the necessary mandatory training available.

I recommend that child care workers employed by child caring agencies meet certification standards to be established by the government.

I recommend that supervisors employed by child caring agencies meet certification standards developed by the government.

I recommend that the province make the training necessary to achieve the above available.

It will remain unknown whether Lester's fate would have been any different if the people employed to protect him had been better educated and better trained. It is clear that the education gap contributed to the difficulties in his life.

## C. POLITICAL INTERFERENCE

I am convinced that political interference has contributed greatly to the failure of DOCFS.

Ernie Daniels, the former Executive Director of DOTC, was very helpful to the inquest on this issue. Mr. Daniels held that position from 1988 to 1990, and he stated that one of his major goals during his tenure was to work towards de-politicising DOTC generally. To Mr. Daniels it was very clear that if a band councillor, no matter what his portfolio, and no matter what his name, attempted to directly interfere with the work of a child care worker, that was political interference and it was unacceptable. There was no difference to Mr. Daniels between interference in child care, or interference in policing - they were both wrong.

Vic Savino, DOCFS' Winnipeg lawyer, was just as clear on this point as was Ernie Daniels. I asked Mr. Savino if in his opinion a band councillor had any more of a right to intervene in a child abuse case than an MLA would have the right to intervene. Mr. Savino candidly answered "no". To Mr. Savino it was self-evident that a child care agency on a reserve, or anywhere else for that matter, had to be able to operate solely on the basis of its perception of the best interests of the children it was legally obligated to protect. The racial origin of the children was completely irrelevant. In Mr. Savino's opinion an aboriginal child care agency had to be able to operate at arm's length for

precisely the reasons that a non-aboriginal child care agency had to have the ability to do so. Arms's length operation by an agency is vital to proper child care work.

However, this principle was not self-evident to many of the DOCFS witnesses who testified at this inquest, nor did it seem clear to the Director, and hence the necessity of this chapter.

The term "political interference" has been used at this inquest to refer to wrongful interference by chiefs and councillors in the affairs of DOCFS and DOTC Police. Numerous examples of political interference have been described by witnesses.

Counsel for DOCFS points out that not every involvement by a reserve politician in a DOCFS and DOTC Police related matter is improper. For instance, it is perfectly acceptable for a councillor to discuss DOCFS operations at a council meeting. It is also perfectly acceptable for a councillor to discuss a case with a DOCFS worker if asked to do so by an affected constituent. Of course, counsel for DOCFS is correct. Reserve residents ask councillors for assistance in the same way that non reserve residents ask their reeves, councillors, or MLA's for assistance. But there is a clear difference between assistance from a politician, and interference. An MLA would be acting in a completely improper way if she told a child care worker to desist from apprehending a child, or if she attempted to set

limiting conditions for that worker. A band councillor doing that would also be acting improperly.

In order to make clear what I mean when I use the term "political interference", that is, wrongful interference by a chief, councillor, or other reserve official, I will list some of the examples that were offered at this inquest. Each of these examples has a story attached to it, but for the sake of brevity I will give only the briefest of descriptions in this report. The examples are listed in no particular order. The list is not exhaustive.

> - Ellen Cook described her experience as a school teacher at Easterville, Manitoba. Her daughter came home one day and told her that the daughter's friend had had sex with the phys-ed teacher. That teacher was the school board chairman's son. There had been previous reports of this same teacher sexually using other school girls. Concerned teachers held a number of secret meetings. The meetings were held in secret because the teachers were afraid for their jobs. Finally teachers decided to write a letter outlining their concerns. It was signed "concerned staff persons ". Ellen Cook decided that as she was the most well established teacher in the community she would perform the task of taking the letter to the principal. The principal, also afraid of losing his job, went directly to the chairman with the letter. The chairman photocopied the letters and called all the teachers together and demanded that Ellen Cook apologize and reveal the names of the other teachers involved. She refused to do so and the chairman had her fired.
>
> - Ellen Cook described a sexual abuse case that came to her attention in 1991. The child care agency for the area was

the Awassis Agency. The alleged abuser was the grandfather of a powerful family on the reserve. The child care worker was so afraid to call the family and do an investigation that her knees were visibly shaking. The worker believed that her job would be in jeopardy if she made the call. In that case charges were eventually laid although, true to form, nothing came of them in spite of a thorough police investigation. The point in this case is not whether or not the worker did lose her job, but the true fear that the worker had that if she reported this incident involving a powerful family her job would be placed in jeopardy.

- Constable Ralph Roulette of the Ontario Provincial Police Force described an incident that occurred at the Birdtail Sioux Reserve when he was a constable with DOTC Police. Mr. Roulette had evidence that the chief's son was guilty of the offence of impaired driving. The chief ordered Mr. Roulette not to charge his son. Eventually Mr. Roulette was forced to get a transfer from Birdtail Sioux.

- Mr. Roulette described a similar situation that occurred when he was a constable with DOTC Police on the Long Plains Reserve. In his experience as a DOTC Police officer he met with what he described as "a lot of political interference from chiefs and councillors".

- Constable Edward Riglin of the Brandon City Police described incidents of political interference that took place when he was a constable with DOTC Police from 1986 to 1990. Constable Riglin was personally threatened with a band council resolution (BCR) banning him from the reserve on a number of occasions because he insisted on charging influential reserve residents with criminal offences.

- Constable Riglin described an incident at Sandy Bay where he stopped the daughter of a band councillor after a

high speed chase. The band councillor physically assaulted Constable Riglin and threatened him with being "BCR'd".

- On another occasion at Sandy Bay Constable Riglin arrested a suspended driver and was again threatened with a BCR. (Constable Riglin is a non-aboriginal person and the threat of a BCR was real).

- Constable Riglin requested a transfer from Sandy Bay detachment because of the pressure caused by the constant threat of BCR's.

- Constable Riglin described the day when the Aboriginal Justice Inquiry came to Sandy Bay. Constable Riglin's wife wanted to make a submission and Cecil Desjarlais refused to allow her name to be placed on the list of presenters. It was only when Constable Riglin surreptitiously slipped a note to Associate Chief Judge Murray Sinclair that Judge Sinclair became aware that Mrs. Riglin wanted to speak (Judge Sinclair then allowed her to speak).

- Constable Riglin testified that Sandra Beaulieu and Delores Roulette, DOCFS workers, confided to him that the political pressure on them is enormous.

- Deputy Chief Warren Fontaine of DOTC Police worked as a police officer at Sandy Bay from 1987 to 1989, at which time he was the senior police officer at Sandy Bay. In 1988 he charged Harry Desjarlais with an offence under the Highway Traffic Act. Mr. Fontaine was advised by the Chief of Police, Bart Hawkins, that Harry Desjarlais was preparing a band council resolution to have all DOTC Police evicted from the reserve.

- Deputy Chief Fontaine described an occasion where he was trying to arrest an enraged Joe Desjarlais from the home of a woman who claimed that Joe Desjarlais had raped her and that she was fearful of being raped again. Cecil Desjarlais was very angry with Deputy

Chief Fontaine for intervening, and threatened Fontaine.

- In December 1991 Deputy Chief Fontaine was aware of an incident involving a family member of Morris Merrick. Morris Merrick threatened to have the DOTC constable fired for his involvement.

- Deputy Chief Fontaine testified that as recently as three weeks prior to his testimony at this inquest the chief of Long Plains was demanding his resignation, for laying appropriate criminal charges.

- Constable Al Miller of the DOTC Police described a conversation that he had with a DOCFS worker at Sandy Bay. The worker told him that she did not want to apprehend the children of a particular band councillor in spite of the fact that they were in need of protection. The worker told him candidly that it was simply out of the question to consider apprehending a child from the particular family involved. In other words, certain families at Sandy Bay were "off limits" to DOCFS. Constable Miller's testimony about that conversation is very significant. It confirms my impression that although examples of cases where workers were specifically prevented from apprehending children from powerful families were relatively few, the much greater problem is the fact that workers do not have the freedom to act according to their perception of the best interests of children in cases where the children come from powerful families. Two standards of care exist.

- Joyce Wasicuna worked at DOCFS as a child protection worker from October 1988 to August 1990. She described looking for documentation concerning a case that originated from the Long Plains Reserve, and involved two children who had contracted gonorrhea from their parents. Morris Merrick told her that he knew nothing about it, but after searching the file Joyce Wasicuna discovered that Morris Merrick had been

the key worker at the time. He definitely knew about it, and for reasons unknown, Morris Merrick did not acknowledge his involvement to Joyce Wasicuna, and did not investigate the case properly. In Joyce Wasicuna's opinion, Morris Merrick stopped the investigation for reasons that Joyce Wasicuna surmised must have involved pressure from influential reserve residents.

- After Joyce Wasicuna and her family moved to Sioux Valley she described receiving threats from people who were very angry that Joyce Wasicuna was thoroughly investigating sexual abuse cases. The point here is that the chief and band councillors gave her no support at all, and in fact supported the people who did not want her to investigate.

- In one sexual abuse investigation undertaken by Joyce Wasicuna she involved a constable with DOTC Police. Pressure mounted in the community to have the constable "BCR'd".

- Again at Sioux Valley, Joyce Wasicuna discussed a sexual abuse investigation with the band councillor who held the child welfare portfolio. Instead of supporting her, the band councillor tried to stop her from continuing with the investigation.

- Joyce Wasicuna was constantly told that thoroughly investigating child sexual abuse complaints was wrong and contrary to the "Indian way". In other words, these things should simply be left alone and not exposed.

- Joyce Wasicuna described in graphic detail how her life and the life of her family was made intolerable by residents at the Sioux Valley Reserve who were upset because she insisted on thoroughly investigating child sexual abuse cases. Her son's motorcycle was burned. Her daughter was threatened with rape. Mrs. Wasicuna was actually chased down No. 1 Highway by an irate reserve politician.

- Ella McKay described a case in which she was involved where a political authority was being investigated for sexual abuse. Ms. McKay was convinced that the child should be apprehended and removed from the reserve, but because of the influence of the child's family, who were politically in power at the time, she was prevented from placing the child in what she believed was the proper home.

- Bev Flett described a case she worked on where a band councillor insisted on having the agency provide a family service worker at $55.00 a day to babysit his children, and he was successful in doing this This money would come from DOCFS funds.

- Bev Flett also described how DOTC had requested DOCFS to pay the legal expenses of Chief Angus Starr, who was suing Ralph Roulette for statements made at this inquest. (Isaac Beaulieu actually tries to defend this ludicrous decision by the chiefs. To take money from a child welfare agency to pay a chief's legal costs demonstrates a clear lack of understanding of child welfare principles and requirements by the chiefs. The fact that DOCFS agreed with this inappropriate request or demand from the chiefs demonstrates why intervention by the province is necessary. Isaac Beaulieu's rationalization demonstrates why Isaac Beaulieu cannot be depended upon to make sound child welfare decisions. Mr. Beaulieu disagrees with DOCFS's decision to agree to pay the legal expenses of Angus Starr, but attempts to rationalize the decision by saying that if the chief is successful in obtaining damages from the person he is suing, DOCFS will get its money back). This final example is very significant because it involves a decision made very recently. It further destroys the suggestion by DOCFS that their agency is a better run agency than it was in 1988.

These are some of the examples of "political interference" that came forward at this inquest. The involvement of the chiefs, councillors, and other reserve officials in the above examples cannot be justified. They are not examples of elected officials responding properly to concerns of their constituents. They are all examples of improper interference and meddling by people who were abusing their offices.

Whether or not the reserve official had a technical legal right to intervene is not the point any more than it would be in the case of a non-reserve official. It could be argued that a cabinet minister has the legal right to intervene directly in a child abuse investigation but it would simply be unthinkable for the minister to do so. It would be improper for many reasons. It is just as improper for a reserve official to do so. Services, such as child welfare and policing, would grind to a halt if reserve politicians interfered at will in the day to day operations of these services.

Counsel for DOCFS cautions against "tarring all chiefs and councillors with the same brush". I accept counsel's suggestion, and I do not wish to leave the impression that all aboriginal politicians interfere. They don't. I will provide some examples in this chapter of aboriginal politicians who recognized the importance of not interfering, and who played a positive role with respect to agencies working in their community. However, I am

convinced by the evidence that came forward at this inquest that the problem of political interference is very real - too many reserve officials interfere too often. This is preventing DOCFS from properly and effectively carrying out its duties. I am also convinced by the evidence that political interference is not a problem peculiar to the Sandy Bay Reserve, or to the DOTC reserves. It is a problem that exists in all of Manitoba's reserve communities. I will discuss this problem in this chapter.

An extremely important point about the examples of political interference that I have listed is that the people who provided the examples knew what political interference was, and they knew that it was wrong. For instance, in the case of the police examples the police officers involved reported these matters to their head office, and their superior (then DOTC Chief of Police Bart Hawkins) supported his officers and made sure that the interfering chiefs and councillors did not succeed. There is evidence to the effect that the present DOTC Police Chief, Frank McKay, stands behind his officers in the same way. That is, it is irrelevant to the police chief whether a person is a chief, a band councillor, or a powerful person on a reserve. If that person, or his brother or uncle has committed an offence, that person must receive the same treatment as any other reserve resident.

That is the only way a police force can function. Ernie Daniels recognized that clearly. He acknowledged that

while he could only act on allegations of interference if they came to his attention, if a case involving interference by a chief or councillor in police operations was brought to him, he would do everything in his power to put an end to the interference.

Mr. Daniels said the same thing about child welfare. The fact that a local child welfare committee is involved with child welfare matters makes no difference to the principle that the councillor or chief, no matter what that person's portfolio might be, or no matter who that person is, is not entitled to interfere directly in a child welfare case.

DOCFS actually acknowledged internally in 1988 that they were not being allowed to investigate child abuse cases at Sandy Bay because of interference. DOCFS witnesses were not being candid at the inquest when they denied that political interference was hurting them. At the meeting of May 5, 1988 (Exhibit 43) the senior DOCFS staff acknowledged that this was a problem. It is stated at the third page of an internal DOCFS minute (Exhibit 43, obtained privately by Marion Glover) under the heading "Child Abuse - Sandy Bay":

> "DOCFS has not been allowed to fully investigate allegations of child abuse on Sandy Bay. This is causing concern as the province is now possibly monitoring those cases..."

Ella McKay and Bev Flett told the true story about the impact of political interference on DOCFS operations. But the rest of DOCFS, in 1992, not only fail to condemn political interference, they attempt to justify it.

Political interference was also a concern of the Govereau/Chudzik Review (Appendix V of Exhibit 53(b) ). The province knew that political interference was preventing DOCFS from properly investigating child abuse cases.

I was astonished by Assistant Deputy Minister James Bakken's testimony when he was given an opportunity to comment about direct interference into child abuse investigations by chiefs and band councillors. I would have expected him to say that interference is completely unacceptable to the Director - that his delegate child care agencies must have the freedom and independence necessary to perform their duties as set out in The Child and Family Services Act. I would have expected the Director to make it clear that not only was interference completely unacceptable, whether it involved an aboriginal agency or a non-aboriginal agency, but that his delegates must do everything they can to oppose that type of interference. And if the agencies allow interference of this kind the Director will insist that they either rectify the problem or surrender their mandate.

Sadly, that is not what Mr. Bakken said. When given an opportunity to condemn political interference, he seemed to say that it was alright with him, as long as the aboriginal

agencies did not complain about it. It was alright with Mr. Bakken if aboriginal child care agencies let local politicians dictate policy to them, no matter how this impacted on the children they were supposed to be protecting. In a nutshell, he implied that this was none of the Director's business.

The Director knew in 1988 that political interference was preventing his delegate agency from doing its job. He did nothing about it. In 1992 the Director not only refuses to admit that this was an error on his part, he implies that interference in the operations of an aboriginal child care agency is not his concern.

What the explanation is for this attitude on the part of the Director I do not know. I will comment further on the government's "hands-off" policy in more detail later in this report, but even within that extremely cautious government policy, Mr. Bakken and his colleagues appeared to be at the most cautious end, to the point of being invisible.

The Director clearly wanted to see aboriginal agencies succeed. The Director also knew that aboriginal agencies have always regarded provincial legislation in the child welfare field as interim only until a national aboriginal child welfare system was implemented. They have resisted accepting provincial "intrusion". Perhaps this plays a part in the Director's "pathological benevolence", which is the term Dr. Charles Ferguson used to describe the Director's

extreme reluctance to intervene in matters involving aboriginal child welfare agencies. I do not know. But whatever the explanation may be, the Director's attitude was and is wrong. The Director should have insisted from the start that aboriginal child welfare agencies operate without political interference. The laissez faire attitude he took to this issue has contributed to the serious nature of the political interference problems on Manitoba's reserves today.

Mr. Bakken did not appear to understand or would not acknowledge that unopposed political interference in the operation of a child care agency prevents an agency from carrying out its statutory duties. The more candid witnesses at this inquest, aboriginal and non-aboriginal, clearly recognized that a Child care agency must have the ability to operate without interference. I mentioned earlier that some examples were given at this inquest of aboriginal politicians on reserves who recognized the extreme importance of allowing child welfare agencies to operate at arm's length, and I will now describe those examples.

The first example is given by Marion Glover. It is an example of a chief and council who understood the importance of child welfare work, and understood the importance of not involving themselves in the day to day workings of DOCFS. This was the leadership of the Dakota Plains Reserve. Chief Ernie Smoke is the hereditary chief of that reserve, and

Marion Glover had to assume the role of child care worker there for a time, because the former DOCFS worker was fired as a result of a serious drinking problem. Marion Glover described the chief and the community as being very supportive of child welfare workers. There was no interference, and in fact only co-operation from the chief and the rest of the community. As a result child care workers could concentrate on child welfare work.

Another good example of this recognition took place at Sandy Bay. Chief Harry Desjarlais was described by Marion Glover as being very supportive of DOCFS' efforts at Sandy Bay, but he did not interfere in the day to day work of the agency. The only exception to that was when Marion Glover involved the chief in the ongoing battle over Annette and Lester, with Danta Kunzman and colleagues. Marion Glover should not have done that. But the point here is that Chief Harry Desjarlais was reluctantly dragged into that fight against his better judgment. On all other occasions, he recognized the importance of placing distance between politics and child welfare. Although he did not always take the same attitude to policing, the chief did not exercise any technical legal right he may have had to involve himself directly in child abuse investigations, and instead respected the arms-length principle.

That is how it should be. There are obviously countless numbers of examples of this recognition of the arms-length principle that have not been provided to this

inquest. However, there are too many examples of the principle not being honoured.

The political leadership on reserves should be very concerned about child welfare workers in their communities. As Dr. Ferguson explained, the Indian leadership should make the safety and well-being of their communities their number one concern. Programs should be developed. The communities should be mobilized. Dr. Ferguson gave his opinion that the Indian leadership has simply not been interested in matters of child welfare and domestic violence. Rix Rogers said the same thing in Reaching for Solutions (Exhibit 83). It is their hope that Indian leaders will come to understand how vitally important these problems are to their communities and begin to take action. However, that action should not include the type of direct interference typified by the harmful meddling of Cecil Desjarlais. That type of interference will only serve to retard any progress that could otherwise be made towards making reserves safer places for families.

Counsel for DOCFS urges extreme caution when non-aboriginal people are tempted to criticize aboriginal people. The criticism may be construed as patronizing, or it may be evidence of racial prejudice. Aboriginal communities differ from non-aboriginal communities, and aboriginal politics differs from non-aboriginal politics. The chief and council system should not be equated with the municipal system.

I accept counsel's submission that there are differences, and that aboriginal people should not be patronized. However, I do not accept the suggestion that aboriginal people should not be subject to criticism where non-aboriginal people would be rightly criticized for the same conduct. It is my firm belief from the evidence I heard at this inquest that political interference is a major problem for the aboriginal community, and that the aboriginal community must solve this problem. Political interference in the operation of a child care agency prevents an agency from protecting children. Period. It has no place in a democratic country. It must be condemned and shut down.

Aboriginal politicians in general are primarily to blame for what is their own doing. At the end of this chapter I will be recommending that the Indian leadership acknowledge this problem and begin the task of regulating and disciplining itself in order to solve it. I reject any suggestion that my criticism is "racially motivated". The criticism relates to the conduct, and not to the racial background, of the people criticized. The criticism is necessary.

As I mentioned earlier, the present position of DOCFS with respect to political interference is not the position that Ernie Daniels attempted to take when he was in charge of DOTC, or the response that former Chief of Police Bart Hawkins, or present Chief of Police Frank McKay appear to

take to these matters, and it directly conflicts with the sound advice that their Winnipeg lawyer, Vic Savino, gives to them. Instead of denunciation of interference and action to stop it, the present DOCFS administration takes the position that there really was no interference at all - this was simply the way local politics on the reserve works. They excused Cecil Desjarlais's actions in the Donna case by saying it was really Marion Glover's fault that he interfered. Throughout these proceedings counsel for DOCFS tried to minimize and explain away any examples of political interference by saying that all of this was "acceptable reserve politics".

I find this current attitude on the part of DOCFS appalling and inexcusable. That political interference exists, and that it is wrong and harmful to child welfare operations on the reserve, is very clear to me from the evidence given at this inquest. It should be clear to DOCFS as well.

Political interference has been documented before. For instance, in the Child Protection Centre's paper "A New Justice For Indian Children" (Exhibit 68) these problems are described. The Aboriginal Justice Inquiry Report, referred to often at this inquest, also describes this problem. For DOCFS to try to minimize this problem and explain it away shows a weakness that is deeply disturbing. DOCFS should be doing everything in its power to fight against the type of

interference described at this inquest. A child care agency cannot possibly do its job if it gives in to it.

The people of Brandon would not accept their mayor or MLA, or even their Premier, directly interfering in the actions of Brandon's Child and Family Services, and particularly so if the child being protected was a close relative of the interfering politician. There is no reason why the people of Sandy Bay should accept such a thing either, differences between aboriginal and non-aboriginal communities and systems notwithstanding.

A child welfare agency cannot function properly if interference is allowed. If a worker has to be selective about which families she will deal with, and which ones she will stay away from, that worker cannot properly carry out her mandate.

DOCFS believes in the consensus approach. DOCFS believes in keeping the family unit intact whenever possible. These are laudable goals. I find no fault with them. But there will be times when there will be no consensus. There will be occasions when the best interests of the child demand that the child be removed from the home or from the community. In short, sometimes people will have to be offended by the necessary actions of a child care worker. Aboriginal people will sometimes disagree, just as non-aboriginal people sometimes disagree. The "disagreements going in and agreement coming out" model of consensus building described by Isaac Beaulieu is an

excellent model, and is one that should interest the non-aboriginal community as well as the aboriginal community. However, it will not always work. As demonstrated very clearly at this inquest, aboriginal people will have different points of view in exactly the same way that non-aboriginal people will have different points of view.

That is why clear lines of authority are necessary. That is why a child care agency, aboriginal or non-aboriginal, must operate at arm's length from its political leadership, and that is why child care agencies must have the ability to denounce unwarranted interference and stand up to interference attempts. The evidence makes it clear that DOCFS does not differ from other aboriginal child care agencies in this regard. At the present time, DOCFS does not have the ability, or even the will to do this.

It is my conclusion that DOCFS and the other aboriginal child care agencies are in great danger from political interference. If the agencies give in to this type of unwarranted interference in their day to day operation, and DOCFS did in this case, it is completely impossible for them to do their job.

I recommend that DOCFS, with the assistance of the Director, develop a written policy, as part of their policy and procedures manual, to deal with this problem. The policy must clearly state that no one from a community, regardless of his official status, can directly interfere in apprehensions, child abuse investigations, or similar

necessary operations of a child care agency. The agency must have the ability to operate at arm's length from politics.

Perhaps the problem of political interference should not surprise anyone. As noted by Dr. Ferguson, aboriginal child care agencies, aboriginal police forces, and other aboriginal agencies are a recent development. It is probable that if non-aboriginal child care agencies had come into being within the last ten years, they would suffer from "political interference" too. But it is also probable that the Director would have intervened at a much earlier stage to prevent the problems from getting out of hand. As I have mentioned many times in this report, the Director has been far too reluctant to intervene in the case of aboriginal agencies and that reluctance has contributed to the problem of political interference continuing to stunt the growth of aboriginal agencies.

Intervention by the Director can help the agencies deal with political interference. But the problem can only be solved by the aboriginal community, and specifically by the Indian leadership. It is clear from the material filed at this inquest that Indian leaders have not been reluctant to denounce paternalism and government policies that they see as being destructive to aboriginal people. But they have been extremely slow to regulate and discipline themselves. Indian leaders have had a decade and more to develop conflict of interest codes and other rules that would have

minimized the problem of political interference. They have failed to do so. They are primarily to blame for the problem. They have demanded much from others, but they have not regulated and disciplined themselves.

I am required to make appropriate recommendations to government or government delegates (in this case DOCFS). I believe that the Indian leadership is now considered a level of government regarding aboriginal issues, although an exact description of the duties and powers of the Indian government are not clear at the time of writing this report. I conclude that I am entitled to make a recommendation to the Indian leadership, and the facts of the case I am dealing with convince me that I should do so.

I recommend that the Indian leadership develop a non-intervention policy concerning agencies operating in their communities under tribal council umbrellas, and I recommend that the Indian leadership develop a conflict of interest code. The failure of Indian leaders to do this in the years since aboriginal agencies came into being has given rise to the very serious problem of political interference. A failure on their part to solve this problem now would constitute proof of both negligence and incompetence.

This ends the portion of my report dealing with political interference. It is a huge problem that must be addressed by DOCFS, but most importantly by the Indian leadership.

A child care agency that cannot stand up to interference cannot do its job, and is not entitled to a mandate. An Indian leadership that cannot discipline itself in not worthy of governing.

## D. SOCIAL PROBLEMS ON RESERVES AND COMMUNITY DENIAL

Much of the evidence heard at this inquest had to do with serious social problems, such as the sexual abuse of children, at the Sandy Bay Reserve. It became clear as the inquest progressed that these problems were not peculiar to Sandy Bay, but were typical of Manitoba's reserve communities. The cause of dysfunctionalism on reserves obviously involves a study of the fields of history, anthropology, sociology and economics, and even then experts will offer very different opinions about this difficult subject. A hearing of this kind is not equipped to deal with questions of such complexity even if it had a mandate to do so.

However, I have concluded that DOCFS was not doing its job in Lester's case, and I have made recommendations designed to help aboriginal child welfare agencies properly protect children. I am convinced by the evidence presented at this inquest that even if these recommendations are accepted, and aboriginal child welfare agencies are greatly improved, their ability to discharge their statutory responsibilities effectively will be severely limited unless change also occurs on the reserves. For this reason I will make some comments about social problems that plague reserves, and the complicating individual and community response of denial. I will then repeat the recommendations that were created by Manitoba's leading child abuse experts to begin the daunting task of addressing these problems -

recommendations that were summarily dismissed by the Indian leadership, and virtually ignored by the governments.

Problems associated with dysfunctionalism , such as alcohol abuse, child abuse and violence are far more extensive and intractable in reserve communities than in non-aboriginal communities. Counsel for DOCFS submits that these problems occur throughout Canada, throughout all levels of society, and that they are not confined to any one racial group. Of course counsel is correct. But his next suggestion, namely that there is no evidence that these social problems are especially acute on Indian reserves, is not correct.

The reasons for this phenomenon are far beyond the abilities of this forum to analyze, but the evidence is overwhelming that the social problems on Indian reserves are grossly out of proportion to those in the nation at large in the same way that the AJI Report found the rate of incarceration of aboriginal people is grossly out of proportion to the national average.

In A New Justice for Indian Children (Exhibit 68) it is stated at p.8:

> "The razing of Indian societies and their traditions is well-documented. Symptoms of this dislocation are evident in high rates of unemployment, suicide, alcoholism, domestic violence, and other social problems. This loss of tradition has seriously damaged the oral means of preserving cultural norms, and the values which prohibit deviant behaviours

> have been obscured and often forgotten...."

and again at p.24:

> "The roots of the problem are complex, yet it is apparent that the destruction of traditional Indian culture has contributed greatly to the incidence of child sexual abuse and other deviant behaviour. Social constraints and solutions have been rendered impotent in the face of conflicting cultures and the massive social disorganization stemming from Indian poverty...."

And "Indian poverty" is certainly one of the biggest parts of this equation, perhaps the single biggest part. The AJI Report states at p.92:

> "In Manitoba, Aboriginal people undoubtedly are the poorest of the poor. Low incomes, unemployment, poor health care, inadequate levels of education, crowded and substandard housing conditions, all are characteristic of Aboriginal life in Canada."

Dr. Charles Ferguson agreed that poverty is a very important part. It was suggested to him by counsel for DOCFS that social problems, such as sexual abuse of children, are pandemic, and that there is no reason to suppose that the problems are any worse on reserves than in the general community. Dr. Ferguson disagreed and suggested that a more meaningful comparison would be between two poverty stricken groups, and not one poverty stricken group compared to a generally middle class group. Indian reserves on the whole are communities where poverty and economic

dependence is the norm. Dr. Ferguson gave his opinion that poverty, and its associated dysfunctionalism, breeds problems like the sexual abuse of children.

The multi-generational pattern of sexual abuse of children on Indian reserves was also noted. In A New Justice for Indian Children, it is stated at p.18:

> "The experience of the project suggests that there are families where a pattern of abuse has been established across three or four generations. Sexually abused children have grown up into abusers who molest other children within the extended family."

Other examples of the very acute nature of social problems on reserves are noted as well. The well known observation of the AJI Report that the likelihood of an aboriginal woman on a reserve being assaulted is one in three, compared to one in ten in the general population, comes to mind (p. 482).

Evidence came forward at this inquest concerning the extra dimension added by residential schools and their controversial legacy. I will not even attempt to set foot in that quagmire.

The evidence is abundantly clear that social problems on reserves are simply enormous. Women and children have no choice but to accept dangerous living environments that would not be tolerated by non-aboriginal people. Perhaps the most graphic summary of this dismal situation came from Dr. Ferguson. He stated flatly that there are hundreds of

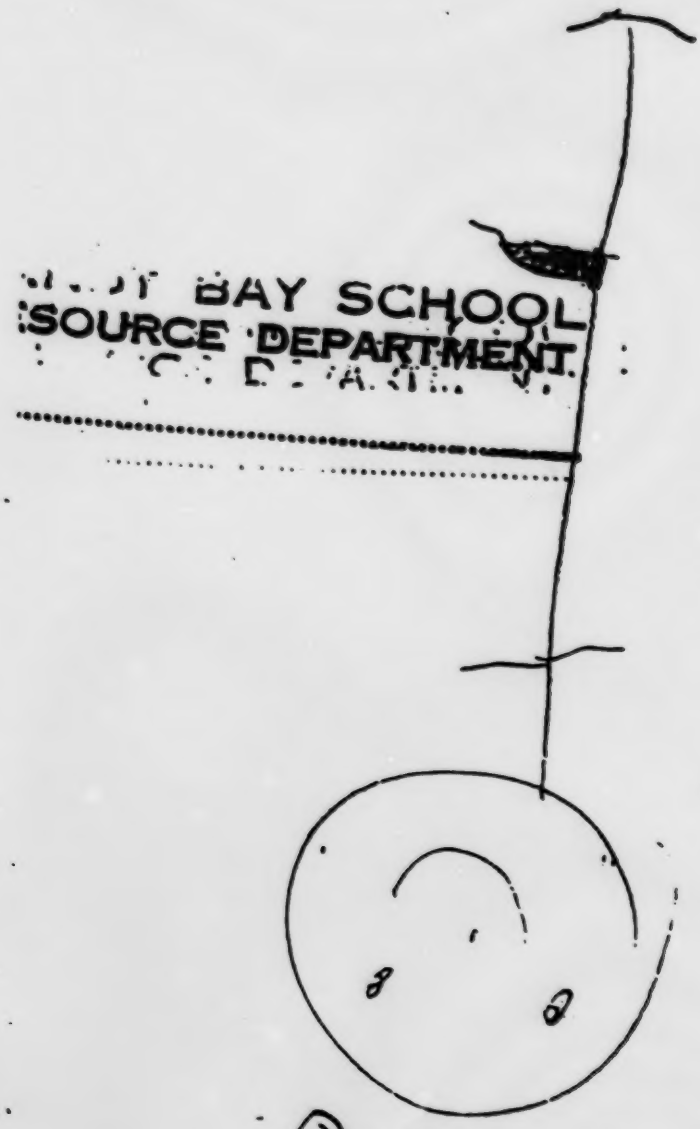
children on reserves in Manitoba today who are being forced to live horrible lives.

Dr. Ferguson also sounded the chilling alarm that the next plague to visit reserves has in fact already begun, but it is receiving no attention. AIDS.

What all of this means for people living on reserves, the great majority of whom are decent, respectable people, is that they are forced to raise their families in a third world environment of dangerous and degrading social problems, overseen by an Indian leadership that in too many cases is more concerned with allegiance to family and friends and the pursuit of political goals than with the welfare of the community. And all of this meets with benign neglect from the government.

What complicates this situation tremendously is the response of most of these communities to the soul-killing multitude of social problems. The response is one of denial and cover-up. I noted earlier in this report that the response of the community of Sandy Bay, in the case of Donna, was to ignore or deny that the problem existed, and when Marion Glover would not let that happen, to attempt to keep the problem from becoming known outside the borders of Sandy Bay. According to Dr. Ferguson and other evidence offered at this inquest, the response of Sandy Bay was typical of other aboriginal communities. He said that there are many factors that strengthen the denial, in this case relating to sexual abuse, in aboriginal communities. The

BAY SCHOOL
SOURCE DEPARTMENT



problems are so severe and intractable that the community response is the response of the untreated sexually abused child, namely "Don't talk, don't feel, don't trust". Dr. Ferguson said that when he first started working with Indian children he predicted that once sexual abuse disclosures were made by Indian children, the Indian community would withdraw and hide the child away. This is exactly what is happening today. The denial is very deep. In this case it even affects the child care agency that is expected to expose these problems and deal with them.

I will provide a rather dramatic visual example of what I am talking about. A drawing done by Donna (found in Exhibit 27) is reproduced on the opposite page. When I saw this drawing I saw a stick man with an exaggerated penis. That is not what Isaac Beaulieu saw when he was asked to look at the picture. He admitted that the drawing might depict a man with a large penis, but said that it could just as easily be a drawing of a sailboat. I can turn this picture around every which way and I still see a man with a large penis and not a sailboat. This example requires no further explanation.

The serious nature of the denial response to sexual abuse of children on reserves is touched on in the landmark study undertaken by the federal government and headed by Rix Rogers. That report is titled "Reaching for Solutions" and is Exhibit 83. It states at p. 108:

> "Only a few years ago, it was very difficult to talk frankly in aboriginal communities about alcohol abuse. Now there is much more openness in discussing the problem, and many community education and treatment initiatives are evident. The sexual abuse of children is still a largely hidden phenomenon and is often denied. Adult abusers whose crime becomes known in their communities may consider themselves disgraced and may sometimes commit suicide. There could hardly be a more volatile or sensitive issue at present."

This opinion is also given in Reaching for Solutions, at p. 106

> "Many band chiefs and councils who have been concentrating on issues like the settlement of land claims have not yet focused on child sexual abuse. Because some aboriginal leaders still do not recognize how crucial child and family services are to their communities, the problem is not being adequately addressed."

It should be noted that Reaching for Solutions was commissioned by the Health and Welfare Canada. It describes the Canadian situation.

The problem of denial in reserve communities also differs in severity from community to community. For instance, Bev Flett, Assistant Executive Director of DOCFS, described the Birdtail Sioux Reserve as being locked in a state of absolute and complete denial. That is, the reserve residents are at the very beginning of the denial process. However, another community, Long Plains, was described by Ms. Flett as being well along the way towards addressing their serious problems. So, two reserve communities, both

under the DOTC umbrella, are at very different stages in the denial process. It goes without saying that communities must confront the problems and openly admit they exist before beginning to heal themselves.

I mentioned that the denial runs deep. It is there at the personal level, at the community level, and has become part of the psyche. It is evident in the testimony of many of the aboriginal witnesses who testified at this inquest. Denial is there, not only in an obvious denial of the seriousness of social problems within the Indian community, but contained as well in the statements made by these witnesses.

For instance, the bald assertions that white children's aid societies were responsible for every imaginable evil is a form of denial. The social problems existing on reserves when "white children's aid societies" were responsible for child welfare on the reserves were probably very similar to the social problems today. I am sure that those agencies had to deal with complex and difficult cases like the cases of Lester, Donna, Allison and the other children discussed at this inquest. To blame those agencies for "the utter devastation of Indian communities" is an excuse for failing to deal with the problems now. It is a form of denial.

The DOCFS claims made by a number of DOCFS employees that everything was fine before Marion Glover was hired, there was a period of confusion while she worked with DOCFS,

and then everything was just fine again after she left is clearly a type of denial.

The fantastic view of "history" that was advanced by witnesses including Cecil Desjarlais must be included in this category as well. In a nutshell it was this: prior to the white man's arrival, Indians lived an idyllic life with peace and harmony prevailing. The white man ruined this story book existence, and has been responsible for all of the bad things Indians have experienced since 1492. More than one witness actually implied that Christopher Columbus was a bad man (presumably because he thought and acted like a man of his time). This preposterous view of "history" was put forward by otherwise intelligent people at the inquest. This is related to denial.

There were other simplistic and wildly exaggerated statements made by witnesses along these lines: the child welfare system is responsible for aboriginal families being destroyed. The education system is responsible for Indian children not doing well in school. The justice system is responsible for the large number of aboriginal people in jails. Residential schools are to blame for almost every conceivable ill, and other blanket statements of this type.

There were also incredible claims put forward about future events. National child welfare legislation would solve all the problems. Self-government, or land claim resolution would make the serious problems disappear. That is, simplistic solutions to complex problems - elementary

school level descriptions stated as fact by otherwise intelligent people for exquisitely complicated unfoldings of history. I believe that this is all related to denial.

This is not to defend any of the things or events described as harmful to people of Indian ancestry. This is also not to criticize any of the goals identified by the Indian leadership as being desirable. The things or events identified as being harmful may in fact be so. The goals identified as being worthy goals, may in fact be just that. My point is that these grossly oversimplified statements and descriptions are used as an excuse, or as a reason for not facing problems and dealing with them now. This is classic denial.

When DOCFS was being strongly criticized by many witnesses at this inquest, Isaac Beaulieu first raised the "lack of resources" defence, and then towards the end of the inquest when it was suggested that DOCFS should be forced to reorganize, Mr. Beaulieu trotted out the "racist" label, saying that any type of intervention would be "racist". He was unable to see a depiction of a man with an oversize penis, and saw a sailboat instead. He was unable to see serious problems, even when they were described to him in graphic detail by DOCFS senior staff, and saw "racism" instead.

I am not implying that denial is something that applies only to aboriginal people. Japanese and German denial after World War II, or the aftermath of the Vichy years, where

virtually everyone in France claimed to have been in the resistance, and no one admitted to being a German collaborator, even to this day, are other well known examples where a traumatic event in the life of a people has resulted in collective denial. But it is clear that for many complex reasons that are not all understood, the denial in the aboriginal communities described by Rix Rogers and Dr. Charles Ferguson is a fact. I am convinced that it is a very significant factor in the problems discussed at this inquest.

Evidence came forward that the denial problem is now receiving a great deal of attention within the aboriginal community. Programs such as "Flying On Your Own" stress healing that can only come after the problems are acknowledged. I have read the material presented by DOCFS concerning the "Flying On Your Own" program and it is obvious to me that many people have done a great deal of very thoughtful work in designing this program specifically for aboriginal people. (The Alkali Lake success story upon which the program is based is well known across Canada). It may not suit every aboriginal person, but it is without doubt a very worthy program, and it is designed to deal head on with precisely the problems that have been discussed at this inquest. Alvin Gervais of DOCFS has given his opinion in a written submission that he has seen many sexual abuse disclosures made during the course of the "Flying On Your Own" program by aboriginal participants. Although not every

aboriginal person accepts the Indian spirituality model that is incorporated in "Flying On Your Own", it is my impression that many aboriginal people could benefit greatly from it, and other similar programs that are developed and run by and for aboriginal people.

The inquest heard about aboriginal communities that have taken responsibility, and have made tremendous strides in dealing with the issue. Alkali Lake in B.C., and Poundmaker's Lodge in Alberta stand out in this regard. These communities have become models for other aboriginal and non-aboriginal communities. In Manitoba we have Hollow Water and the Dr. Jessie Sauteaux Center. The dramatic accomplishments at Pukatawagan in reducing violence are not minor by any means. There are many other brave aboriginal communities that are well on their way in the process of reclaiming their communities, and their true lives.

However, the evidence at this inquest convinces me that there are too many aboriginal people, and indeed entire communities, that are at the very beginning of the denial process. Too many witnesses, like Morris Merrick, talked about being healed, but their evidence and demeanour demonstrated that they still had a long way to go. Overcoming denial is the first step - it is an essential first step.

As I noted when I began this part, this hearing is not equipped to produce anthropological or sociological opinions. The field is very complex. The comments and

opinions that I have included in this report are a tiny corner of a large picture. What is clear is that changes in legislation, government programs, or even constitutional amendments will not make a dent in the present situation on reserves until the communities face the problem. As witness after witness stated, there can be no healing until denial is overcome.

At this point I will leave the specific topic of "denial" and return to the more general topic of social problems on reserves.

I have referred frequently to the paper A New Justice for Indian Children. It was released in October 1987. According to Dr. Ferguson, it received a generally hostile response from the Indian leadership, and a non-response from the government. Dr. Ferguson described the experience of doing the study as being the most difficult that he ever dealt with. He likened the experience to "walking on hot coals". The experience of doing A New Justice, and the results of the report, caused Dr. Ferguson to devote his full time practice to work with the Children's Hospital Child Protection Centre.

For the benefit of readers who are not familiar with Dr. Ferguson and the Child Protection Centre I will give the briefest of descriptions . The centre is headed by Drs. Ferguson, Ken McCrae, and Sally Longstaffe. These three doctors are Manitoba's foremost experts in the area of child abuse. In fact, they are known across Canada for their

experience and expertise. These doctors are recognized as the deans of the child abuse field.

It is not my intention to embarrass with this description, but I do want to make the point that Manitoba's leading experts in child abuse undertook the incredibly difficult and sensitive task of confronting the serious problems existing in Manitoba's reserve communities. They produced a superb report which should have become a blueprint for change. Instead, when the paper was released there were cries of racism from some chiefs, and mumblings about "white people not understanding native ways", (which of course is a classic example of the denial I have referred to). From the government side there was stony silence.

This should not be. These doctors are our best. We should listen to them.

How serious is the problem of child abuse on reserves? Although the exact dimensions of the problem are not clear, the most graphic, and indeed frightening, anecdotal evidence on this point is again offered by Dr. Ferguson. He said at this inquest that during the course of his career he has seen thousands of sexually abused children - from reserves and from Winnipeg. In Winnipeg he finds himself in court constantly as a witness. For the reserve cases he is virtually never called. In other words, the sexual abuse cases from the reserves are not being addressed. This is a blood-chilling indictment of the present situation on reserves. It means quite simply that aboriginal children

are being abused and no one is doing anything about it. A code of silence exists and it is destroying young lives.

I will state the obvious at the conclusion of this chapter; namely that no amount of outside assistance in the form of government programs, legislation or even constitutional change will overcome this code of silence. Only the individual residents of the reserves are capable of putting an end to this so that healing can begin. But even the people who are prepared to brave the system find a depressing lack of services confronting them.

The paucity of services available to reserves to help address the problem is described in A New Justice for Indian Children. It is not a problem unique to Manitoba. In Reaching for Solutions it is stated at p. 106:

> "Aboriginal people say that the question is often not to improve service, but to initiate service because there is so little. Aboriginal communities need access to trained staff, backup support services at a district level and special arrangements to deal with difficult travel conditions."

I will set out below the recommendations made in A New Justice for Indian Children. The AJI Report has already done this and recommended that there be adoption of the recommendations. It became clear to me after considering Dr. Ferguson's testimony and re-reading A New Justice that I must repeat the recommendations and strongly urge their implementation. The additional recommendation that I will make is that the government gather together a task force of

knowledgeable people to assist in implementing these recommendations. Witnesses that stand out as candidates for the task force from this inquest are Joyce Wasicuna and Ellen Cook. This inquest has also heard of well placed people and groups such as the Aboriginal Women's Unity Coalition, Manitoba's Indigenous Women's Collective, and the Ma Maaui Chi Itata non-mandated child care agency in Winnipeg. Names like Cathy Mallet also come to mind. According to many of the witnesses who appeared at this inquest, including Ellen Cook and Dr. Ferguson, there is a strong group of urban aboriginal people who are ready and willing to face these problems directly, and they should be given an opportunity to do so.

The task force I am recommending should certainly not be restricted by race or gender. The Child Protection Centre should be consulted about the composition of the task force. Dr. Ferguson spoke of a male chief in northern Manitoba who was an excellent child care worker before his election as chief. He might be a candidate for this group. Obviously, there are many people, male and female, aboriginal and non-aboriginal who should be considered for the task force. I have suggested the names mentioned at this inquest, but these names are suggestions only, and I am recommending that the government consult with these and other people and groups in order to put together a task force that is progressive and energetic.

Although I am not sufficiently knowledgeable to know who should be on the task force it is my impression that there is energy and expertise in abundance within the aboriginal community, and a tremendous desire to right the wrongs of the past and present. This energy and expertise must be harnessed.

Dr. Ferguson, Ellen Cook, Bev Flett, Ella McKay, Marion Glover and Joyce Wasicuna stand out as the witnesses who best described the extremely important role that aboriginal women must play in rebuilding. Rix Rogers, in Reaching for Solutions, makes the same point for all Canadian reserves, at p. 108:

> "The growing number of concerned aboriginal women is a source of hope for the future. If they receive both moral and financial support to effect the gradual rebuilding of aboriginal cultures, native women can take a lead. Many of these women can be lay counsellors and have an important healing role, although it must be appreciated that many of them may themselves be survivors who need sensitivity training and support."

These witnesses were not describing the "stand by your man" type of role that Isaac Beaulieu and other male aboriginal functionaries preferred. They were talking about aboriginal women taking the lead in dealing with problems that the male leadership was unwilling, or unable to handle.

I was informed that the Assembly of Manitoba Chiefs plans to do a study dealing with the situation of children on reserves. Apparently this decision was made after

hearing Dr. Ferguson's remarks at this inquest. That study may be useful. But in the meantime, the needs of the children referred to by Dr. Ferguson must be addressed. The track record of the Assembly of Manitoba Chiefs on these issues is very poor and too often the response of the chiefs has been to play politics instead of addressing the problems, or to simply condemn governments for past injustices, and then blame the absence of action on the problems on a "lack of resources". I will be recommending at the conclusion of this chapter that the Indian leadership actually start "leading" in the areas of child abuse and other social problems that continue dragging aboriginal people down. In this case I believe that unless chiefs and councillors are prepared to actively cooperate with this process they can serve best by staying out of the way, and by learning from these people.

There is a suggestion that this report should recommend a public inquiry into the operation of DOCFS, or even all of the aboriginal child care agencies in Manitoba. It goes without saying that the government can do as it wishes as far as the calling of inquiries is concerned. I am not recommending a general public inquiry. As has been noted, public inquiries are cumbersome, expensive beasts that move very slowly. Very often the recommendations eventually made are very extensive, well motivated, and entirely unaffordable. It has been suggested that any money could be better spent on making immediate improvements to the system.

I have recommended that the Directorate become actively involved in working on the two main problems I have identified within DOCFS, namely confusion within the DOCFS child care apparatus, and the problem of under educated child care staff, as well as reviewing the DOCFS file system. I have made recommendations involving training and certification. I am also making my recommendations concerning "A New Justice for Indian Children". There will obviously be expense involved if these recommendations are accepted by government. Experienced people may have to be seconded from other agencies and departments, and their replacements will have to be paid. There will be other expense as well. I believe that immediate assistance would be of more help to aboriginal children than possible assistance in the future.

Public inquiries also move very slowly. A final report from such an inquiry might be years away. It seems unlikely to me that the final report could do much better than the recommendations made by Dr. Ferguson, Dr. McCrae and Dr. Longstaffe. These recommendations should have seen the light of day in 1987. It is now 1992. Delaying action for another indefinite period of time while an inquiry process drags on is inexcusable. If an inquiry is deemed absolutely necessary, Dr. Ferguson's recommendations must be implemented now without waiting for a distant report.

For these reasons I am not recommending a general public inquiry. I am recommending immediate action.

Before listing the recommendations made in A New Justice for Indian Children, I will note that I am aware that I will be criticized for making these far-reaching recommendations. I was sent out to do an inquest and answer some related questions, and I have come back with broad recommendations that seem very far removed from the death of one child. However, this is my responsibility as I see it, given the evidence that came forward at this inquest. It was after listening to Dr. Charles Ferguson that I made my decision to write this chapter.

I am also aware that even the complete and comprehensive implementation of these recommendations will not be a solution, but a beginning only. I am sure that the Child Protection Centre recognized that as well. However, I am convinced that Dr. Ferguson's recommendations can serve as a good beginning. Perhaps the task force can also look at recommendations contained in Reaching for Solutions, and other recent studies, and use them as a catalyst in the war by aboriginal people to reclaim their communities.

The recommendations are aimed specifically at child sexual abuse, which is only one problem on a list that includes domestic violence and alcohol abuse. Perhaps other initiatives agreed to by the task force and the government can be undertaken together with the recommendations dealing with child sexual abuse. However, I am convinced that implementation of Dr. Ferguson's recommendations, even as a solo venture, would be better by far than to continue to

rely on the vain hope that the Indian leadership or the Director will take action.

I repeat the recommendations from A New Justice for Indian Children, and I urge their implementation under the guidance and assistance of the task force referred to above. They are as follows:

**RECOMMENDATION #1**

A province-wide initiative should be undertaken to ensure that medical personnel servicing Indian reserves residents have training specific to the problem of child sexual abuse. This should be ongoing, dealing with recognition of medical symptoms and signs, and developing interviewing abilities and discussing the medical role in the multidisciplinary team.

**RECOMMENDATION #2**

All rural detachments of the RCMP should receive additional training in child sexual abuse and the investigation of such cases. As well, RCMP training efforts in this area should be designed to include local tribal police for the dual purpose of maintaining a close relationship and providing these officers with proper information. Training should include the role of the peace officer in a multidisciplinary team.

**RECOMMENDATION #3**

All Crown attorneys and members of the judiciary should receive in-depth training in the dynamics of child sexual abuse. This should include an understanding and appreciation of their potential role in multidisciplinary team. There should also be some consideration of possible options for monitoring offenders and how the Crown can facilitate those options.

**RECOMMENDATION #4**

That the Attorney General's office give serious consideration to developing a program that would address the coordination problems inherent in reserve-based child sexual abuse cases. Such a program would address the issue of consistency, (ie: having the same Crown attorney throughout the case), as well as developing a working relationship with local Justice Committees. One possible option would be to hire legal assistants or paralegals to be based on the reserves for the purpose of facilitating a logical and orderly collaboration on each case. The possibility of developing Tribal Courts should, in our view, be explored by examining the relative success of such in other jurisdictions.

**RECOMMENDATION #5**

A program for preparation of child witnesses in sexual abuse cases should be established for rural areas. Such a program could be conducted either by the Attorney General's Department or local child caring agencies, but in either case new resources would need to be allotted. Currently, children from most reserves receive scant preparation for giving testimony. Such preparation would have the twofold benefit of reducing further trauma to the child and increasing the likelihood of the child participating meaningfully in the court hearing without fear.

**RECOMMENDATION #6**

That a program be initiated to promote the use of a multidisciplinary team approach on every reserve in Manitoba. The focus of such an approach would be tribal elders in conjunction with the local child-caring agency, the local Child Care Committee, and the local Justice and other pertinent Committees. By using such mechanisms as a foundation for a community-based approach, a non-

native institutions and methods can be adapted to use in reserve communities. If such teams demonstrate leadership and a willingness to act, legal and medical professionals from the white system can play a supportive rather than controlling role.

In order for such a program to be successful, there must be considerable training and preparation. One possibility might be to hire one "multidisciplinary facilitator" per reserve, and conduct initial training in Winnipeg in conjunction with the Child Protection Centre. The literature review prepared for the Department of Justice gives preliminary indications regarding the content of such training. Such teams, once functional, could consider issues as well as case management (ie: approaches to youth recreation and supervision and access to pornography).

**RECOMMENDATION #7**

It is recommended that there be considerable new resources committed toward developing a treatment capacity in each reserve, for offenders and victims, such resources currently being negligible. The logical vehicle for providing treatment is the local child-care agency, with advice and support from community elders, or perhaps a larger council of elders. Much needed culturally based prevention (personal safety) programs could then be developed for use in reserve schools.

It is clear that an infusion of staff and training would be required to accomplish these goals, given current demands on existent staff.

**RECOMMENDATION #8**

It is recommended that child-caring agencies with the responsibility for the protection of Indian children place a big priority on developing greater numbers of safe placement options for children. This includes the careful

scrutiny of current placement options, as well as possible extended family placements. The development of innovative new safe places for child victims is an undertaking that would optimally be conducted in conjunction with Child Care Committees and multidisciplinary teams as they become operative.

**RECOMMENDATION #9**

Experience with the Child Advocacy Project suggests that the above recommendations regardless of their potential worth, would have little chance of realization without some co-ordinative influence. This would take several forms (eg: a provincial co-ordinator specifically for reserve based child abuse situations). It is thought crucial that integrative and organizational efforts take place with some input from hierarchies of all involved disciplines.

The implementation of any or all of the above recommendations may serve to improve the network of systems that work to protect Indian children from child sexual abuse. The degree to which any of these changes make impacts will be determined partially by the spirit with which they are undertaken. The acknowledgement of native people's rights to control their lives and communities is a fundamental part of that spirit.

Many of the changes contained herein are significant departures from current practice. The need for bold action is apparent. Children are suffering from trauma, physical injury, and psychological devastation that result from sexual abuse. The injuries to self-esteem, trust, and emotional functioning last a lifetime. The incidence of sniffing, alcohol abuse, eating disorders, suicide, depression, and sexual acting out among Indian children suggest that the problem of child sexual abuse has reached epidemic proportions.

> The social cost of child sexual abuse is higher than we can imagine. These child victims continue to be victimized throughout their lives. The burden of this victimization is preventing many Indian children from becoming the healthy, functioning adults they might otherwise be. The failure of the social, medical, and legal systems to provide a safe environment for the normal development of these child (sic) perpetrates the existence of future generations of victims. It is time to break the cycle of victimization. It is time to break the longstanding pattern of non-action on reserve-based child sexual abuse. Quite simply, it is time for a new justice for Indian children.

My final recommendation with regard to social problems on reserves, and community denial, involves the Indian leadership. I noted in my chapter dealing with political interference that the Indian leadership appears to be, or at least is in the process of becoming, another level of government. That entails accountability. I believe that it is appropriate and necessary in 1992 to hold the Indian leadership to account in a report of this kind in the same way that the provincial government is taken to task.

The problems of child abuse, domestic abuse and related social problems on reserves are problems of gigantic proportions, and the Indian leadership has failed to adequately address them.

I recommend that the Indian leadership make solving these evils their number one priority. When I make this recommendation I am not talking about verbal action only on the part of Indian leaders. Complaining about past and

present government policies and making demands on governments, without doing more, is not "solving" these problems. I am suggesting that the Indian leadership and the aboriginal community accept ownership of the problems in a way they have failed to do before. Only then can the leadership and communities work towards solutions.

I am entitled to make recommendations to governments in a report of this kind. No specific authority exists allowing an inquest judge to make recommendations to private individuals and communities. However, I cannot properly end this chapter without repeating the obvious. This was a theme repeated by many concerned witnesses. Aboriginal communities must take responsibility for their problems and take the lead in their solutions. If that does not happen the best conceived and motivated plans will come to nothing.

I urge reserve communities and individuals in these communities to confront problems in an open manner and deal with them. If your current leaders are not prepared to take the lead, find people who are prepared to accept the task. There are communities that have begun this process and they can serve as models. But you must do it.

I urge aboriginal communities to learn from the death of Lester Desjarlais.

## E. ABSENCE OF DIRECTOR

I have read that it is not true that ostriches stick their heads in the sand. Newcomers to the African plain saw the birds feeding, with their heads hidden in the tall grass, and thought they were seeing birds with their heads buried in the ground. So the myth was born. But it is an extremely useful picture, and in my opinion describes exactly the response of the directorate, in particular the responses of James Bakken and John Chudzik, to the child abuse problems at Sandy Bay, the problems within DOCFS, and to aboriginal child welfare matters generally.

I am convinced by the evidence that the virtual absence of the Director has contributed to the problems in this case. I believe that the Director's "marching orders" from the government, essentially a "hands-off" policy with respect to aboriginal child welfare agencies, has compromised the lives of aboriginal children living on reserves, and continues to this day to deprive too many aboriginal children in this province of their birthright as Canadians - namely the right to true childhoods. I am convinced by the evidence presented at this inquest that if these children are to have a chance the government must discard its "hands-off" policy, and adopt a "hands-on" policy. The Director must "direct". I will explain my reasoning.

The "Director" is technically the Director of Child and Family Services, formerly called the Director of Child

Welfare. He or she is appointed pursuant to Section 3 of The Child and Family Services Act S.M. 1985-86, c.8 C80. When I use the term "Director" in this report I am referring to the Director of Child and Family Services. My term "Director" is to be read as one and the same as the "directorate", namely the Director and his or her staff.

The duties of the Director are set out in Section 4(1) of the Act. They are as follows:

> 4(1) Under the control and direction of the minister, the director shall:
> (a) administer and enforce the provisions of this Act;
> (b) advise the minister on matters relating to child and family services;
> (c)) advise agencies;
> (d) ensure the development and establishment of standards of services and practices and procedures to be followed where services are provided to children and families;
> (e) ensure that agencies are providing the standard of services and are following the procedures and practices established pursuant to clause (d) and by the provisions of this Act and the regulations;
> (f) receive and hear complaints from any person affected by the administrative actions of an agency;
> (g) exercise the powers and duties of an agency in any area in which no agency is functioning;
> (h) supervise or direct the supervision of children in care, and receive and disburse moneys payable for their maintenance;
> (i) protect children in need of protection;
> (j) ensure the development of appropriate placement resources for children;
> (k) submit a yearly budget for the child and family services system and keep

> books of account of all moneys received and disbursed by the director;
> (l) prepare and submit an annual report to the minister;
> (m) perform such other duties as may be prescribed by this Act, by the regulations, or as may be required by the minister.

The powers of the Director are as set out in Section 4(2). They are as follows:

> 4(2) For the purpose of carrying out the provisions of this Act, the director may
> (a) inspect any treatment centre, group home or other home or place in which a child is placed in accordance with the provisions of this Act;
> (b) examine the records respecting a child in any of the places mentioned in clause (a);
> (c) conduct enquiries and carry out investigations with respect to the welfare of any child dealt with under this Act;
> (d) establish Boards to hear complaints under clause (1)(f);
> (e) solicit, accept and review reports from individuals or organizations concerned or involved with the welfare of children, families, or both;
> (f) designate in writing a place or type of places as a place of safety for the purposes of this Act;
> (g) issue a written directive to an agency;
> (h) do any other thing in accordance with the provisions of this Act that the minister may require.

In practice the Director does not become involved in ongoing child protection work. These functions are delegated to child care agencies pursuant to Section 4(3). DOCFS is such an agency. However, the Director has extensive powers and he is responsible for the welfare of children of all races in Manitoba.

Aboriginal child care agencies are obligated to perform duties identical to the duties of other child care agencies. The duties are set out in Section 7(1) of the Act. They are as follows:

> 7(1) According to standards established by the director and subject to the authority of the director every agency shall:
> (a) work with other human service systems to resolve problems in the social and community environment likely to place children and families at risk;
> (b) provide family counselling, guidance and other services to families for the prevention of circumstances requiring the placement of children in protective care or in treatment programs;
> (c) provide family guidance, counselling, supervision and other services to families for the protection of children;
> (d) investigate allegations or evidence that children may be in need of protection;
> (e) protect children;
> (f) develop and provide services which will assist families in re-establishing their ability to care for their children;
> (g) provide care for children in its care;
> (h) develop permanency plans for all children in its care with a view to establishing a normal family life for these children;
> (i) provide adoption services where appropriate for children in its permanent care;
> (j) provide post-adoption services to families and adults;
> (k) provide parenting education and other supportive services and assistance to children who are parents, with a view to ensuring a stable and workable plan for them and their children;
> (l) develop and maintain child care resources;

> (m) provide services which respect the cultural and linguistic heritage of families and children;
> (n) provide such reports as the director may require;
> (o) take reasonable measures to make known in the community the services the agency provides;
> (p) conform to a written directive of the director;
> (q) maintain such records as are required for the administration or enforcement of any provision of this Act or the regulations;
> (r) provide any other services and perform any other duties given to it by this Act or by the director in accordance with this Act.

The one difference between aboriginal agencies and other agencies is found in Declaration II of the Act's Declaration of Principles. It states:

> "II. Indian bands are entitled to the provision of child and family services in a manner which respects their unique status as aboriginal peoples."

The current Director is Ron Fenwick. The Director at the time periods most relevant to this case, namely 1987-1989 was James Bakken. Mr. Bakken is now the Assistant Deputy Minister of The Child and Family Services Division of The Department of Family Services. In the structure of the department he is Mr. Fenwick's superior. Mr. Bakken testified at this inquest.

My reading of the role of the Director is that although the Director has very broad powers, the practise is to allow child care agencies to operate with the minimum intervention by the Director. The Director is there as a support to

agencies, and to assist when an agency is experiencing problems.

In the cases of Lester and Donna the Director intervened on two occasions. The first intervention occurred after Marion Glover was fired by DOCFS, in July, 1988. Mr. Bakken knew some of the details about the dispute between Marion Glover and DOCFS prior to his meeting with Ms. Glover after her firing. Marion Glover asked to meet with Mr. Bakken, and when she arrived at his office for their meeting, she was startled to find that Mr. Bakken insisted on having legal counsel present during the meeting. At that meeting Marion Glover provided basically the same information to Mr. Bakken that she subsequently provided to this inquest.

Mr. Bakken instructed two members of his staff, Wayne Govereau and John Chudzik, to conduct an investigation into the complaints, and to provide a report. For reasons that have not been adequately explained, no report was provided. Instead, the Director was given notes made by Mr. Govereau and Mr. Chudzik. These notes are Appendix V of Exhibit 53(b).

The primary focus of this investigation was supposed to be the welfare of Sandy Bay children. But DOCFS opposed the involvement of the Director from the start, and the Director seemed to be unable to overcome this opposition. Political considerations quickly overpowered concerns about the children, and the results of the review were unsatisfactory.

No report was provided, and although serious problems, both within DOCFS and at Sandy Bay, were uncovered by the Govereau/Chudzik intervention, the Director appeared to do nothing significant to ensure that the problems were addressed. The Director appeared to be stymied.

The DOCFS position taken with respect to the Govereau/Chudzik Review was to stonewall, and then to attempt to blame all problems on Marion Glover. It was apparent to Mr. Govereau and Mr. Chudzik that there were many problems that were completely independent of Marion Glover. But for reasons which are not clear, Mr. Chudzik and Mr. Govereau allowed DOCFS to manipulate the situation: they listened to DOCFS gossip about Marion Glover "sleeping with chiefs" and other embarrassing irrelevancies - they appeared to be afraid of offending DOCFS. The Director seemed to have this same fear. The entire episode demonstrated an attitude on the part of the Director that can only be described as timid.

In fact this was no intervention at all. The Director only did what DOCFS gave him permission to do. It took months before DOCFS let the Director carry out his "review", and even then the "intervention" was on terms set by DOCFS. The Director allowed himself to be bullied.

The next intervention by the Director took place in January 1992. By this time Mr. Bakken had become the Assistant Deputy Minister of the same department, and Ron Fenwick had become the Director. This second intervention

occurred only because of media pressure resulting from Marion Glover's statements to the press following her appearance at this inquest in October, 1991. The Department was forced to become involved.

Between the time of the Govereau/Chudzik Review in 1988 and the Department's intervention in January, 1992, the Director appeared to be content to monitor developments, and to take a passive role with DOCFS. The initiatives taken by the Director in response to the problems uncovered by Mr. Govereau and Mr. Chudzik were extremely weak, and amounted to very little. They were more in the nature of "window-dressing" than true attempts to deal with the real problems. It seems very unlikely to me that the Director would have intervened at all in January, 1992 if it had not been for the media pressure, and the pressure from the Ombudsman.

The problems revealed by the Govereau/Chudzik Review were very serious problems. It should have been very clear to the Director that he must play an active role. His delegate was not doing its job. The Director did nothing of substance to solve the problems.

When the Department was impelled to intervene in January, 1992, the method chosen was extremely odd. In effect Mr. Bakken, now Assistant Deputy Minister, reviewed the action he himself took, or did not take in 1988, when he was the Director. When questioned about this, Mr. Bakken said that he failed to see anything wrong with the method

chosen. I do. It was entirely improper. This "review" of a "review" was a farce.

The report obtained was Exhibit 53(a). I have indicated previously that it is not within the mandate of this inquest to sit in judgment on the actual report. I will simply note that I disagree with its findings for the reasons given in this report. The Ombudsman is pursuing this aspect of the case.

The Director only became involved with DOCFS when there was no other choice. He withdrew as soon as he could, and did almost nothing to correct a situation that he knew was seriously out of kilter. Mr. Bakken stated that the Director does not intervene in the affairs of one of its delegates unless it is necessary. It should have been abundantly clear to the Director that intervention was necessary in this case, but only token steps were taken.

Caution is understandable, prudence is commendable. Consensus building is a wonderful goal. But where the welfare of children is concerned, matters such as the "upcoming elections" and other extraneous factors referred to in the report (53(a) ) and presumably considered by the Director should have been irrelevant.

It is my conclusion that the Director did not properly carry out his duties listed under Section 4(1) of the Act in this case. He was far too worried about offending DOCFS and the Indian leadership. He was far too concerned about the political fall-out of his actions. He was not concerned

enough about what should have been his paramount concern - the safety and welfare of the children of Sandy Bay.

The virtual absence of the Director from aboriginal child welfare matters is not confined to the case of DOCFS. In the opinion of Dr. Charles Ferguson, in the last ten years the Director has been "almost pathologically benevolent in the case of aboriginal agencies." This extreme caution has been criticized very recently in the Suche Report (Ex.60).

The director's extreme caution was the wrong policy. If the Director had intervened when the serious problems first came to the surface, the situation might not have deteriorated to such an extent. In my opinion it was wrong for the Director to do nothing of substance after it was clear that DOCFS was not doing its job properly. I want to make it clear when I make these comments that I am criticizing individuals only to the extent that these individuals were responsible for developing departmental policy. My criticism is of the policy and not of individuals. The cases of Lester and Donna demonstrate clearly that the departmental policy was misguided.

However, I do not apologize for singling out Mr. Bakken and Mr. Chudzik. It is my belief that both of these individuals acted far too cautiously, even within the narrow confines of the "hands off" policy of the government within which they were operating. I also cannot dismiss from my mind the fact that both Mr. Bakken and Mr. Chudzik knew of

the existence of the Donna Desjarlais abuse file (Exhibit 107) that was not made known to the inquest until Bev Flett came forward in the last two days of the inquest. The fact that neither Mr. Chudzik nor Mr. Bakken informed Lawrence McInnes or his colleagues about the existence of this new file, either when they first found out about it on June 2, 1992, or when the file came to their office on June 5, 1992, or at the very least when Mr. Bakken testified for the second time at the inquest on June 16, 1992, has caused me great concern, and I admit to being completely puzzled by their actions. At the least, assuming these people knew that the inquest had no knowledge of this new file as of June 16, 1992, their actions are further confirmation that the departmental policy was seriously wrong.

I must also comment about my extreme disappointment in the testimony given by representatives from the directorate. Perhaps it is not fair to include these comments, because the inquest heard the testimony of only a few representatives of that department. However, it was my impression that these were "bureaucrats" pure and simple, as Dr. Charles Ferguson had described and not people who had first and foremost a passionate commitment to child welfare. I had assumed that such a commitment would be there, at least among people with important responsibilities. Listening to the deliberately obscure "bureaucratese" of Mr. Bakken on May 19, 1992, and his failure to condemn political interference noted earlier, the extremely cautious language

of Mr. Chudzik, and the rationalizations of Mrs. Mathers my reaction was one of profound disappointment, and above all a concern for the state of aboriginal child welfare in this province. As I said before, I heard evidence from a few people from the directorate only. Perhaps they are not representative of their department, or perhaps I misinterpreted what they were saying. If so, I apologize. But I decided not to leave this unsaid. The welfare of children, aboriginal and non-aboriginal, must be the first concern of the directorate.

Viewing the actions of the Director from the time of Lester's death until June 16, 1992, I have come to the conclusion that Dr. Charles Ferguson's term "pathological benevolence" is not only accurate, but rather kind.

The Director was afraid of offending the Indian leadership. He was determined to maintain peace. He succeeded. Peace was maintained at the expense of children.

As mentioned in the conclusion of my chapter entitled "Confusion Within DOCFS" I am criticizing not only this government but previous governments for their failure to become involved in aboriginal child welfare matters. When I criticize the Director I recognize that I am criticizing government policy. I have given my opinion that this policy has compromised a generation of Indian children. This is the fault of the provincial government, the federal government, and the Indian leadership.

Reference was made at the inquest to the historical origins of the aboriginal child welfare agencies. I have referred to the "history" about the "60's scoop", given by numerous witnesses. A rosy picture was painted by many witnesses concerning the transfer of child welfare responsibility to aboriginal agencies in the late 70's and early 80's. It consisted of aboriginal visionaries convincing the governments that aboriginal child welfare matters should become the responsibility of the aboriginal community, and the provincial government delegating these responsibilities in an orderly and responsible way to an aboriginal community that was ready and able to assume this huge responsibility.

As I mentioned at page 179 another version emerges from the evidence that is closer to the truth. It is Dr. Charles Ferguson's view that the Indian leadership "did not realize what they were getting into" when they assumed responsibility for child welfare. It is my reading of the evidence that the aboriginal community did not have the expertise necessary to suddenly assume responsibility for child welfare. The Indian leadership had no idea of the magnitude of the child welfare related problems on reserves, and the government acted in unseemly haste in turning matters over to the aboriginal community without the necessary funds, training, and other essentials. It is true that the Indian leadership was demanding the immediate transfer of child welfare responsibility with no strings

attached. However, it is my opinion from the evidence that the government of the day acted irresponsibly in giving in to these demands without making sure that the newly created agencies were able to function properly.

The transition should have been done in an orderly fashion, and in stages. The government should have ensured that workers employed by aboriginal child welfare agencies were properly trained. The government should have worked very closely with the newly created agencies and carefully monitored their progress. They did none of these things. Instead, responsibility for some of the most difficult and intractable child welfare cases in the system was turned over to people who in too many cases had only "life experience" and an aboriginal heritage to prepare them for this momentus task.

The Indian leadership was both foolish and naive when it demanded complete transfer and control of child welfare responsibility with as little involvement from the Director as possible. The government's compliance with demands from the Indian leadership for immediate and uncontrolled transfer was an abdication of responsibility. For the government to have insisted that a transfer would have to be done in an orderly way in stages, and that the Director would insist on remaining actively involved with the emerging aboriginal child welfare agencies, would have been neither "paternalistic" nor "racist". It would have been

the responsible thing to do. It would have been an exercise of simple common sense.

As mentioned, I agree with Dr. Ferguson's "pathologically benevolent" term in Lester and Donna's cases, and I find that John Chudzik's "extremely cautious" comment is far too mild to properly describe the Director's policy. However, regardless of the semantics, the point is that the approach was wrong. I recommend that the Director be required to actively intervene, and stay involved, until it is clear that the problems have been solved within DOCFS. I recommend that the Director monitor the situation with DOCFS, and ensure that the progress is maintained.

Further, I recommend that government policy with regard to aboriginal child welfare agencies in general be changed. Government policy should acknowledge that the provincial government is responsible for the welfare of aboriginal children in the same way that the government is responsible in the case of non-aboriginal children. In recognition of the many problems that exist for aboriginal child welfare agencies, and the serious problems that exist within the communities they serve, I recommend that the government develop a policy that is neither "pathologically benevolent", or "extremely cautious", but instead is activist in nature. Prudence, sensitivity, and caution are all desirable. However, the important point for the government, at least at this time, is to recognize that the aboriginal child welfare agencies need help, guidance and

vigorous assistance. Unless and until the present constitutional arrangement is altered, the help, guidance and assistance can come only from the provincial government. I recommend that the government abandon the "hands-off" policy and replace it with a "hands-on" policy.

It is quite clear that the Indian leadership will not welcome such a policy change. A court challenge might be the result. A call for legislative change might be the result. How this will turn out is anybody's guess. However, the present state of affairs is intolerable. Aboriginal children living on reserves remain in the "limbo" described by Graeme Garson (then Judge Garson) in 1979 (AJI Report, page 521 - Exhibit 73(f). The "life and death" policy continues, only in the form of the "hand-off" policy. I urge the government to change this weak non-policy and (unless and until aboriginal child welfare becomes the responsibility of another government) accept its responsibility.

(i) Office of The Child Advocate

My last recommendation has to do with the Office of the Child Advocate. I understand that a Bill is currently before the Legislature on this subject, and therefore I want to be very careful with my comments. I am aware that I should not be venturing onto the political playing field. However, at the risk of criticism, I am going to discuss the subject, because I am convinced that the issues raised at this inquest, and in particular the case of Donna, demonstrate very clearly why the Child Advocate is so necessary.

If that is all that I was going to say about the Child Advocate, I don't think I would be offending anyone. Associate Chief Judge Kimelman recommended ten years ago that the Child Advocate or Protector position be created. His recommendation was repeated in other reports and papers, including the AJI Report. It is my understanding that there now exists an agreement in principle that Judge Kimelman's recommendation will be implemented.

But that is not all that I am going to say, because as I see it, this case and specifically the way that Marion Glover's complaints were dealt with by the Director in this case demonstrate in a crystal-clear way why it is absolutely necessary that the Child Advocate must report to the Legislature. That is also the way Manitoba's senior child welfare judge, Associate Chief Judge Ed Kimmelman, envisioned the position, and that is the way Associate Chief

Judge C.M. Sinclair and Associate Chief Justice A.C Hamilton saw it as well. The Child Advocate must report to the Legislature.

I will set out my reasoning below, but before I do, I want to apologize for what appears to be an intrusion into political matters. At least at the time of writing, I am aware that the question of whether or not the Child Advocate should report to the Legislature has not been resolved. So clearly a judge should not involve himself in a political debate. The conundrum is that I formed my opinion on this subject before the issue became political, and if I omit the recommendation from my report, I will be leaving out an opinion that I am convinced is very important. Let me also say that I am buttressed in my opinion by Dr. Charles Ferguson, who gave his opinion in very definite terms at this inquest that it is absolutely fundamental that the Child Advocate report to the Legislature. I will explain why I think that this is so important.

When Marion Glover went to Winnipeg to meet with Mr. Bakken and bare her soul to him, she expected that the Director of Child Welfare would listen, and that his first concern would be child welfare. She was wrong. She met with a Director who had legal counsel with him. She met with stony silence. The actions taken by the Director from that point on demonstrate clearly that politics, fear of offending the Indian leadership, and other extraneous

considerations were the priorities. Child welfare appeared to be well back on the list.

This must be contrasted with Marion Glover's visit to the Ombudsman. The Ombudsman enjoys an independence akin to that of a judge. That is, it is expected that he should not worry too much about whom he offends. His job is to bulldoze his way through to the matter under investigation. And that is the way it should be. When Marion Glover came to him the Ombudsman listened, and then made a plan to investigate the matter. Whether or not Marion Glover was politically dangerous or even a "wingnut" (in Sgt. Fisher's terms) was not the first concern of the Ombudsman. "Upcoming elections", fear of offending the Indian leadership, or protection of superiors were not on his mind. Properly investigating the matter was.

In my opinion the Child Advocate must be granted the same type of independence as that granted to the Ombudsman. Otherwise "upcoming elections" and a hundred other extraneous considerations will get in the way of what the Child Advocate is expected to do.

Therefore, I recommend that the Office of the Child Advocate be created, and that the Child Advocate report to the Legislature.

As her first assignment, I request that the Child Advocate monitor the Director's response to the recommendations I make in this report (assuming that the government accepts the recommendations) and ensure that the

Director is indeed directing in accordance with his statutory duties. I regret that this is necessary, but because of the Director's determined absence from aboriginal child welfare matters in the past ten years, and the directorate's demonstrated weakness at this inquest, this request must be made.

This ends my chapter dealing with the Director, and this also ends my report. I have made recommendations for change in the body of this report. In order for the recommendations to be understood, the report must be read as a whole, and consequently I will not add a summary of the recommendations. I will end with this postscript:

Council for DOCFS suggests that if a microscope was taken to any child care agency in the way that this inquest has examined DOCFS, problems as serious as the ones revealed at this inquest would come to life. Maybe so. I hope not. What is clear to me is that Lester Desjarlais had the right to expect more. His family let him down; his community let him down; his leaders let him down; then the very agency that was mandated to protect him let him down, and the government chose not to notice. Lester deserved something better.

It is a sad fact of life that some parents fail their children. We have a child welfare system designed to take the place of the parent in those situations. The welfare of children is supposed to come first in our system. In Lester's case it did not.

Children must come first!

**LESTER DESJARLAIS INQUEST**

**WITNESS LIST**

**October 7, 1991**

Caroline Anne FISHER
Sergeant with the City of Brandon Police involved with the investigation of the missing files.

Constable Nicholas Norman GREENHILL
RCMP Constable who attended at the suicide scene.

Paul Albert ROY
Neighbour of Maxine and Angus Starr who helped cut down the body of Lester Desjarlais.

Maxine STARR
Daughter of Angus Joseph Starr and Lillian Starr.

Angus Joseph STARR
Husband of Maxine Starr, and now Chief of the Sandy Bay Band.

Joseph Adelard DESJARLAIS
Alleged sexual abuser of Lester and other children and adults at Sandy Bay.

Cecil DESJARLAIS
Brother of Joseph Adelard Desjarlais, and Sandy Bay politician alleged to have interfered in child abuse investigations at Sandy Bay.

Nicholas Franklin PETRINACK
Pathologist

Morris MERRICK
Executive Director of Dakota Ojibway Child and Family Services

Elaine SCOTT
Supervisor with Dakota Ojibway Child and Family Services.

Margaret Anne RAINNE
Secretary at DOCFS

Ernest Ronald MOUSSEAU
He succeeded Marion Glover as DOCFS supervisor for Sandy Bay, and is currently under suspension for alleged sexual abuse of DOCFS foster child, and related matters.

William George RICHARD
Child care worker at Sandy Bay

**October 8, 1991**

John CHUDZIK
Child abuse co-ordinator for the province of Manitoba.

Olga HART
DOCFS secretary

Doreen Elizabeth LOANE
DOCFS off-reserve worker for Brandon and area.

Hedie Louise EPP
Senior employee with the Office of the Chief Medical Examiner who was assigned the task of preparing a report concerning Lester's death.

**October 9, 1991**

Esther SEIDL
Former Executive Director of DOCFS

Donald Albert BECHTEL
RCMP constable involved in the investigation of the missing files.

Marion Florence GLOVER
No explanation necessary.

**October 10, 1991**

Lillian STARR
Lester's foster parent at his final placement who found the noose that Lester later used to hang himself.

**April 6, 1992**

Danta KUNZMAN
Former DOCFS off-reserve worker for Winnipeg and area.

**April 7, 1992**

Trudy Marilyn YU
Donna's teacher at Sandy Bay Elementary School.

Angela Agatha EASTMAN
Vice-principal of Sandy Bay Elementary School.

Virginia ROULETTE & Arthur ROULETTE
Relatives of Lester. Lester stayed at their home for periods of time on a number of occasions and regarded their home as a safe refuge.

**April 8, 1992**

Claudia HOULE
Sandy Bay resident and foster parent.

Ellen COOK
School teacher and social activist.

Dennis ROULETTE
Former DOCFS child care worker who burned DOCFS files at the request of Cecil Desjarlais.

**April 9, 1992**

Al Miller
DOTC Police constable.

Elaine SCOTT
Above

**April 14, 1992**

Elaine SCOTT
Above

**April 15, 1992**

Ralph Joseph ROULETTE
Constable with the Ontario Provincial Police and former Sandy Bay resident who alleged that Angus Joseph Starr sexually assaulted him.

Angus Joseph STARR
Above.

Ralph Joseph ROULETTE
Above

Edward Raymond RIGLIN
City of Brandon police constable and former DOCFS constable at Sandy Bay who complained of political interference.

Sergeant Albert Anthony CLARK
Amaranth RCMP

Sergeant John ROACH
RCMP officer involved with polygraph tests later refused by Marion Glover.

**April 16, 1992**

Constable Michael Stuart DRUMMOND
RCMP Constable involved in searching for Lester's missing school files.

Elizabeth Jane MCLEOD
Brandon Mental Health Centre social worker involved with Lester on all three of his admissions to BMHC.

**April 29, 1992**

Constable Randal Miles MCGINNIS
RCMP constable formerly stationed at Amaranth detachment and involved with the thwarted apprehension of Donna.

Donald Patrick HANNAH
Former resource teacher at Sandy Bay Elementary School who reported sexual abuse concerns about Donna on November 30, 1989.

Wilfred MOUSSEAU
Former Director of Finance for DOCFS at Sandy Bay and presently advisor to the Rousseau River Reserve gathered evidence about false travel claims at the request of DOCFS head office for the purpose of firing Marion Glover.

Theresa Shirley CONTOIS
Friend of Marion Glover's who overheard Mr. Mousseau telling Marion Glover that he had lied at the DOCFS-Glover arbitration proceedings.

Doreen Elizabeth LOANE
Above

**April 30, 1992**

William Wayne HAMILTON
Former principal of Sandy Bay Elementary School.

Arthur William BLUE
Clinical psychologist who prepared the report re Donna.

Warren John FONTAINE
Deputy Chief of the DOTC Police who gave examples of political interference at Sandy Bay and elsewhere.

**May 1, 1992**

Angus Edward STARR
Former resident of Sandy Bay who was implicated by Angus Joseph Starr as the possible sexual abuser of Ralph Roulette.

Warren John FONTAINE
Above.

Delores Iona ROULETTE
DOCFS head office employee, formerly employed by DOCFS as child care worker at Sandy Bay

Ernest Ronald MOUSSEAU
Above

**May 4, 1992**

Ernest Ronald MOUSSEAU
Above

**May 5, 1992**

Sandra Joan BEAULIEU
Former DOCFS child care worker at Sandy Bay.

William George RICHARD
Above

**May 6, 1992**

Marilyn Dawn BARR
Career Development Councillor, formerly employed as a resource teacher at Sandy Bay elementary school. Ms. Barr became convinced that Donna had been sexually abused and was involved in bringing her concerns to the attention of the school principal.

**May 11, 1992**

Georgina Wanda HOULE
Former DOCFS child care worker at Sandy Bay.

**May 12, 1992**

Doctor Ronald Alvin RICHERT
Psychologist who had involvement with Donna.

Caroline Joyce WASICUNA
Former DOCFS child protection worker for DOTC Sioux Reserves.

**May 13, 1992**

Bruce Terence FRASER
Former Executive Director of Child and Family Services of Western Manitoba.

**May 15, 1992**

Evelyn Doris MATHERS
Co-ordinator for children in care with the Department of Child and Family Services who investigated Donna's current status in January, 1992.

**May 19, 1992**

James Orville BAKKEN
Assistant Deputy Minister of the Child and Family Services Division of the Department of Family Services. In 1987-88 he was the Director of Child Welfare.

**May 20, 1992**

Isaac Beaulieu
Chairman of DOCFS for most periods of time since the inception of the organization (now technically Vice-Chairman)

**May 21, 1992**

Cecil Desjarlais
Above

**May 22, 1992**

Isaac BEAULIEU
Above

Victor Stephen SAVINO
Winnipeg lawyer for DOCFS

**May 25, 1992**

Doctor Charles Anderson FERGUSON
Senior doctor with Child Protection Centre

Sergeant Caroline Ann FISHER
Above

**May 26, 1992**

George Ernest DANIEL
Former Executive Director of DOTC

**May 27, 1992**

Marion Florence GLOVER
Above

**May 29, 1992**

Isaac BEAULIEU
Above

**June 1, 1992**

Marion Florence GLOVER
Above

**June 2, 1992**

Marion Florence GLOVER
Above

**June 3, 1992**

Marion Florence GLOVER
Above

**June 4, 1992**

Victor Stephen SAVINO
Above

Marion Florence GLOVER
Above

**June 15, 1992**

Gerald Wayne GOVEREAU
Former Native Services Co-ordinator for Directorate, involved with John Chudzik in the "Chudzik/Govereau Review".

Isaac BEAULIEU
Above

June 16, 1992

James Orville BAKKEN
Above

June 17, 1992

Isaac BEAULIEU
Above

Beverly Jean FLETT
Current DOCFS Assistant Director for Ojibway communities

Ella Judith MCKAY
DOCFS supervisor

June 18, 1992

Ella Judith MCKAY
Above

Beverley Jean FLETT
Above

Isaac BEAULIEU
Above

June 19, 1992

Isaac BEAULIEU
Above

June 22, 1992

Beverley Jean FLETT - recalled
Above

Isaac BEAULIEU
Above

Morris Clark MERRICK
Above

June 23, 1992

Morris Clark MERRICK
Above

Sherri Lisa MCIVOR
Sister of Lester

**EXHIBIT LIST**

1. BCP report of Carol Fisher
2. Letter from Esther Seidl to Constable Fisher
3. 5 photographs of deceased
4. RCMP report on deceased
5. Letter from T. Meindl (Jan 25, 1989)
6. Statement of Darlene Spence
7. Statement of Linus Wood
8. Medical Examiner's report - Dr. Petrinack
9. Autopsy Report - Dr. Nair
10. Letter from Marion Glover to Jim Bakken of Child and Family Support, Winnipeg
11. BMHC file on deceased (two files)
12. Seven Oaks file on deceased (two files)
13. Death report to Charlotte Olson, Minister of Family Services
14. Guidelines for Identification and Reporting Child in Need of Protection
15. DOCFS file on deceased (#5050-C)
16. DOCFS file on Joyce Desjarlais (#5050)
17. DOCFS personnel file on Marion Glover
18. Memo to E. Seidl and M. Merrick from Danta Kunzman - Nov 19, 1987
19. Memo to M. Merrick from Danta Kunzman - Dec 21, 1987
20. Memo to E. Seidl from M. Merrick - undated
21. Letter from Const. Bechtel, RCMP, to Hedie Epp, Medical Examiner's office
22. Handwritten and typed statement of Joyce Desjarlais
23. Adjudication Decision re Marion Glover v. DOTC - Appendix of Exhibits attached
24. Resume of J. Waddell
25. "Ode to Lester" from school children
26. File #5050 - master file Joyce Desjarlais
27. File #5159A - master file and working file - Donna Desjarlais
28. Adjudication material from Freda Steel
29. School file for Donna Desjarlais - CUM file Sandy Bay School
30. Marion Glover personnel file
31. file #5050A DOCFS Sherry (Desjarlais) McIvor - master and working file
32. file #5050B - Nancy (Desjarlais) McIvor - master and working file
33. file #5050C - Reconstructed file of Lester Desjarlais
34. file #5050D - Allison Desjarlais - master file
35. file #5050E - Sherold Desjarlais - master file
36. file #5050F - Annette Desjarlais
37. News Release (3 pages)
38. Letter dated July 23, 1987 to Esther Seidl
39. Newspaper article - Winnipeg Sun - Dec 22, 1991
40. 3 Newspaper articles - first, second & final of series

41. April 13, 1984 - Manitoba Guidelines on Identification and Reporting Child Abuse
42. Sample minutes local Child Abuse Committee
43. Minutes of Meeting 0 May 5, 1988
44. Case Plan (Part I) re: Whitford, Houle, Levasseur
45a. School file - Donna Desjarlais
45b. School file - Donna Desjarlais with cover page "Me"
46. RCMP file #88-0602
47. RCMP file #88-0563
48. Job Description - DOCFS Co-ordinator
49. Job Description - DOCFS Child Protection Worker
50. Letter from Joe Desjarlais dated April 10, 1992
51. RCMP Continuation Report
52. Amaranth RCMP sexual assaults - Sandy Bay
53a. Report on handling child abuse cases
53b. Appendices
54. Drawings and notes of Lester Desjarlais given to Georgina Houle by Sherri McIvor
55. Allison Desjarlais abuse file
56. Lester's Circle of Love - Family Tree
57. Long Plains abuse file
58. Termination letter - Fraser to Marion Glover
59. Letter from Ron Fenwick to Judge Giesbrecht
60. Suche Report
61. Band Council Resolution & Indentifying Information
62. Memo from Tim Maloney dated Jan 17, 1984
63. Curriculum Vitae of Isaac Beaulieu
64. DOTC Resolution
65. Mr. Savino's file on Lester Desjarlais
66. Letter dated April 25/88 to V. Savino from E. Seidl and Mr. Merrick
67. Memo Jan 21/88 to M. Glover from E. Seidl
68. Report - A New Justice for Indian Children
69. Allison Desjarlais field file
70. Statement of Lee Edward Baker
71. Letter - CAS Central to M. Glover - July 5/85
72. Letter - CAS Central to M. Glover - Mar 18/86
73. Materials presented by Isaac Beaulieu (see attached)
74. New Careers material (see attached)
75. M. Glover letter to Ombudsman - Jan 3/92
76. Press Release of M. Glover May 11/92
77. Letter - Mitch Podolak to L. McInnes - May 25, 1992
78. Annual DOCFS Report - Sandy Bay portion
79. Letter - Jan 15/88 - Glover to R. Chambers and reply Jan 26/88
80. 2 Informations re: "Failure to Appear - Marion Glover"
81. Staff Development Manual - Gull Harbour - Sept 87
82. Government Response to Suche Report
83. Reaching for Solutions - Report to Minister of National Health
84. RCMP Report - Whitford, Houle, Levasseur
85. July 4/88 letter from E. Seidl to J. Bakken
86. Certificate of Conviction - Marion Glover
87. Notice of Apprehension of Donna Desjarlais Feb 29/88

88. 1985/88 Sandy Bay Tribal Council Organizational Chart
89. Package of DOCFS documents produced by Isaac Beaulieu
    a. letter to I. Beaulieu from J.R. Rose
       Director of Child Welfare dated June 24, 1981
    b. Letter to all child care agencies from R. Alcock
       Director of Child and Family Services - Oct 27/83
    c. Agreement of Transfer
    d. DOCFS General By-Law
    e. DOTC CFS 1980
    f. Child Welfare Committees
    g. Executive Director
    h. Child Care II - Senior
    i. Job Bulletin
    j. DOCFS Performance Evaluation
    k. DOTC Administrations Policy Manual
    l. Child & Family Services Act
    m. Background History
    n. Guide for LCWC Members on weekend call
    o. DOCFS Receiving Home
90. Examples of correspondence outlining legitimate
    involvement of chiefs & councils of DOCFS
91. Training for local committees
92. Letters outlining legislative contact
93. Feb 6/92 letter to D. Paterson from Christine Buchel
    Asst Director of C & F Supporc
94. Letter from Gordon Earle, Ombudsman, to Harold
    Gilleshammer May 27/92
95. Program Standards Manual CFS to be returned to I. Frost
96. Letter Jim Bakken to Dr. Peter Markesteyn - May 9/88
97. Letter Jim Bakken to E. Seidl Sep 2/88
98. Package of letters to E. Seidl from J. Bakken Sep 27/88
99. Resolution of DOCFS June 11/92
    a. letter Apr 27/92
    b. DOCFS Agency Review-proposed Working Group Budget
    c. Proposes re-organization of DOCFS
100. Workshop Abuse Pamphlet
101. Letter to E. Seidl from Chief Henry Desjarlais Sep 4/87
102. Documents pertaining to the burning of files
     Dennis Roulette
103. a. Procedure Manual C&FS Western - 1983
     b. CFS Western Policy Manual
104. Declaration of Kirk Creed
105. Declaration of Sophie Gordon
106. Police Article Re: Tribal Police - March 6/89
107. Abuse file - Donald and Donalda Desjarlais - #5082
108. DOCFS Mandate and Terms of Reference
109. Letter from E. Seidl re: Mr. Merrick - June 3/92
110. DOCFS Case Load - June 1992
111. Letter Nov 19/87 to DOCFS from CFS Central
112. 1985 letters pertaining to John James Jr.
113. Letters concerning Flying on Your Own
114. Letter from I. Frost to L. McInnes - June 22/92

Exhibit 73 - Materials presented by Isaac Beaulieu consists of:

a. Video re DOCFS - 1983
b. Random notes re Lester
c. Past Minutes of Meeting - RCWC
d. Samples of Board Minutes - 4 binders
e. Yellowquill Study
f. AJI Report
g. Kimelman Report - No Quiet Place
h. Hudson Report - 1984
i. 5 Videos - Child Abuse Workshop - 1988
    i. Dr. Charles Ferguson
    ii. Alex Laurence
    iii. Dr. Eric Ellis
    iv. Dr. Eric Ellis
    v. Kathy King - RCMP
j. 2 Videos - DOCFS Workshop - Elkhorn Ranch
    i. April 3/89
    ii. April 5/89
k. 1 Video - Community Workshop - Sioux Valley - Sexual Abuse
l. Memo from Ron Mousseau dated Dec 5/91
m. Child Abuse: Investigation and Assessments
n. Medicine Wheel Approach - West Region CFS

Exhibit 74 - New Careers Material
Consists of:

a. Memorandum from Louise Gordon to Lawrence McInnes accompanying material
b. Competency Based Training Plan - June 17/91 - June 11/93
c. On-The-Job Evaluation - June 17/91 - June 11/93
d. Module 1A - June 17-21/91 Introduction to Work and Training
e. Module 1B - June 24-28/91 - Communication Skills
f. Module 2A - August 26-30/91 - Helping and Communication Skills
g. Module 2B - Sept 3-6/91 The Aboriginal Perspectives
h. Module 3 - November 4-15/91 - Protection Services
i. Module 4A - January 27-31/92 - Effective Group Behaviour
j. Module 4B - February 3-7/92 - Case Management
k. Module 5 - March 30-April 10/92 - Child Abuse
l. Module 5 - March 30-April 10/92 - Child Abuse Articles
m. Child and Family Service Court Work Brandon Group
n. Aboriginal Child and Family Service Workers Time Management January 31/92

**THE FATALITY INQUIRIES ACT**

**REPORT BY PROVINCIAL JUDGE ON INQUEST**

**RESPECTING THE DEATH OF**

**LESTER NORMAN DESJARLAIS**

**DATED AT THE CITY OF BRANDON, IN THE PROVINCE OF MANITOBA THIS 31ST DAY OF AUGUST, 1992.**

**ASSOCIATE CHIEF PROVINCIAL JUDGE**
**BRIAN DALE GIESBRECHT**